The GMC’s role in continuing professional development: Annexes
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Review of the GMC’s role in doctors’ continuing professional development: final report
Doctors’ have a duty to keep their knowledge and skills up to date. This continuing professional development (CPD) is an integral part of doctors’ professionalism. Although it should be rewarding in its own right, CPD is not an end in itself. Its purpose is to enable doctors to continue to provide high standards of care for their patients throughout their careers.

As the regulator, the GMC is responsible for ensuring that doctors maintain those high standards and that their participation in CPD activities supports the better care of patients and the public.

This review has focused on how doctors should approach their CPD, how employers and others can create a culture and environment which supports appropriate CPD and the GMC’s role in promoting awareness of relevant CPD.

Unlike undergraduate and postgraduate training, there is no formal CPD curriculum for all doctors to follow. Nor should there be. Each doctor’s CPD needs will be different, depending on the role they are undertaking, the needs of the service in which they are working and, above all, the needs of their patients and the community. The identification of those learning needs and agreement on how they are to be addressed should therefore be the responsibility of the individual doctor in discussion with the individuals, teams and organisations with which they work. The principal mechanisms for this are personal development plans, job planning and appraisal.

The GMC’s role in regulating doctors’ CPD is not to prescribe what CPD doctors must do or how they must do it, but to provide a framework of principles around which doctors should plan, undertake and evaluate their CPD activity. The guidance which accompanies this report provides that framework of principles. To have their full effect they must be embedded in the processes for appraisal and in the way appraisal is quality assured. By using appraisal to confirm that doctors are practising to the appropriate standards revalidation will provide assurance that they are participating properly in CPD.

Primary responsibility for doctors’ continuing learning rests with doctors themselves. But they must be supported in this by a workplace culture which provides opportunities for all staff to maintain and develop their skills. This applies not just to consultants but equally to groups which sometimes struggle to access resources for their CPD, such as locums, sessional GPs and staff grade doctors. A number of recent reports have recognised the importance of institutional support for CPD. The framework provided by our guidance offers a proportionate approach which balances the legitimate interests of employers and contractors of doctors’ services with the needs of doctors.

The GMC is not a provider of CPD and apart from in those areas where it has particular expertise related to its role as the regulator, it should not become one. However, the GMC’s unique position makes it well placed to bring to the notice of doctors trends and issues affecting their professional practice and key developments in medicine which are relevant for all doctors. It has already begun to do this in isolated instances and the introduction of revalidation will make this more important in the future. This will help doctors to reflect on their learning needs and decide what CPD will be most valuable for them in meeting the needs of their patients.

Executive summary
Section 1: Background

1 Lord Patel’s March 2010 report Recommendations and Options for the Future Regulation of Education and Training examined how the GMC’s role would need to develop in the light of the responsibilities it was about to take on for regulating postgraduate medical education and training. That report also recognised that doctors’ learning does not end with the completion of formal postgraduate training and nor does the responsibility of the GMC.

2 Once out of training doctors still have most of their careers ahead of them. During that time what they learnt at medical school and in postgraduate training will need to be updated to reflect changes in practice and technology, and in society’s expectations of the way doctors’ practice.

3 Doctors anticipate and respond to those changing demands through CPD. The onus is on them to show that they are maintaining appropriate professional standards. Revalidation will provide the public with assurance that they are doing so and evidence of participation in CPD will be part of that assurance.

4 The challenge for the GMC is to regulate doctors’ CPD activity in a way which serves the interests of patients, while also supporting doctors and recognising the needs of those who employ or contract their services.

5 Lord Patel noted that the GMC had issued CPD guidance for doctors in 2004. But he was mindful that much had moved on. His report therefore recommended that:

‘The GMC should update its 2004 CPD guidance and re-examine how the regulatory role in CPD should be exercised so as to support doctors in meeting the requirements of revalidation and providing high quality care for their patients, whilst preserving the value of CPD for individual professionals.’

6 Lord Patel’s recommendation provided the impetus for a review of the GMC’s role in doctors’ CPD. This report sets out the conclusions of that review.

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3 Ibid, review recommendation 20

4 World Federation for Medical Education, Continuing Professional Development (CPD) of Medical Doctors: WFME Global Standards for Quality Improvement, WFME Office, University of Copenhagen, Denmark, 2003, p6.

5 Academy of Medical Royal Colleges, Continued Professional Development: Guidelines for recommended headings under which to describe a College or Faculty Scheme, 2010, p3

Section 2: Defining CPD for doctors

7 The first problem for any regulator becoming involved in CPD is being clear about what it is trying to regulate and why.

8 There is no universally agreed definition of CPD for doctors. However, it is generally understood to refer to all the processes and activities pursued by doctors following their completion of formal postgraduate training that enable them to maintain and continually develop their professional practice. Building on this and with reference to the definitions used by others our review has used the following definition:

A continuing learning process, outside formal undergraduate and postgraduate training, which enables doctors to maintain and improve their performance across all areas of their medical practice through the development of knowledge, skills, attitudes and behaviours. It covers all learning activities, both formal and informal, by which doctors keep up to date.

9 We have also been clear that CPD is not an end in itself. Its purpose is to help improve the safety and quality of care provided for patients and the public. It is therefore linked to doctors’ performance as individuals and as members of teams in the organisations where they work.

10 As we will see in sections 7 and 8 of this report, this definition and purpose of CPD shaped the way the working group felt CPD should be regulated.

Section 3: Remit and objectives of the review

11 The terms of reference for the review are reproduced at Appendix A. Our task was to examine and make recommendations on the GMC’s role in CPD.

12 The required outputs were:

a a report to the Continued Practice, Revalidation and Registration Board and to Council setting out recommendations for the role of the GMC in CPD

b following consultation on the report and draft guidance, an updated version of the GMC’s 2004 CPD guidance.

13 To support our terms of reference and aid our developing thinking we established some underlying principles for the review. These provided a template against which we could test our developing ideas (Appendix B).
Section 4: Working methods

14 A small working group, chaired by a lay member of the GMC, was established to undertake the review. The group comprised medical and lay members from the GMC, as well as representatives from the Academy of Medical Royal Colleges (AoMRC), NHS Employers and the Committee of General Practice Education Directors (COGPED). The full membership is shown at Appendix C.

15 The working group recognised that its thinking needed to be informed by a wider range of views. These were sought in several ways. On 30 March 2011 we held a stakeholder seminar on our emerging ideas. The seminar brought together doctors (including consultants, GPs, SAS grade doctors, and trainees), employers, academics, representatives of the medical royal colleges, departments of health in England and Scotland, deaneries, professional associations and the independent sector, as well as medical and lay members of the GMC’s reference community.

16 Issues arising from the review were also among the topics discussed at two further seminars organised by the GMC for SAS grade doctors and new consultants in May 2011.

17 From March to mid July 2011 we ran an online survey asking doctors’ their views of the GMC’s role in CPD. Details of the survey were widely trailed in the GMC’s e-bulletins to doctors and in the communications of other organisations such as the medical royal colleges. The survey elicited 1,872 responses.

18 As well as considering the regulation of CPD as it relates to medicine in the UK, we also looked at other professions both within and outside the health sector. This was supplemented by a literature review of how regulators worldwide approached this issue.

19 We have also benefited from the results of research into the effectiveness of doctors’ CPD commissioned by the GMC and the AoMRC.5

20 Details of the learning from the seminars, survey, literature review and research are provided in section 6 of this report.

21 To supplement the research and engagement activities already undertaken, we also commissioned longer term research looking at the links between doctors’ participation in CPD and their practice and performance. That research will not be completed before this review reports its conclusions. However, we anticipate that the learning derived from the research will help to inform the GMC’s future work.

22 The working group met on four occasions between November 2010 and July 2011. The recommendations in this report represent the group’s conclusions. They are intended to provide the basis for a full public consultation on our future role.

Section 5: Regulatory context and drivers for change

23 To understand our possible future role in the regulation of CPD, it is first necessary to say something about the context within which we operate and the drivers for change.

The GMC’s position

24 Section 5 of the Medical Act 1983 gives the GMC the ‘general function of promoting high standards of medical education and coordinating all stages of medical education’. These general functions have not, until recently, been accompanied by the sort of specific powers which might give the GMC direct regulatory purchase on doctors’ CPD.

25 Revalidation will give the GMC new legal powers6 and a focus for doctors’ future CPD activity.7 This is because evidence of participation in CPD will be part of the supporting information that doctors will bring to their annual appraisals to show that they are keeping up to date and working to enhance the quality of their practice.

26 For this reason, doctors need clear guidance from the GMC about what is expected of them in relation to CPD and revalidation.8 Our 2004 guidance, Continuing Professional Development, was well received at the time it was published but, as Lord Patel recognised, it is now out of date.

27 More generally, Good Medical Practice (2006) imposes a duty on all doctors to ‘keep [their] knowledge and skills up to date throughout [their] working life’ and ‘regularly take part in educational activities that maintain and further develop [their] competence and performance’. Doctors fulfil that duty through their participation in CPD. How they have done that has been largely left to individual doctors, the medical royal colleges and other providers to get on with.

External drivers for change

28 Revised CPD guidance is one element, but revalidation has also prompted calls for ‘a more rigorous approach’ to CPD and ‘reforms… to the oversight of continuing professional development to support doctors in meeting the requirements of revalidation’9. Importantly for our review, the calls for more rigour have been balanced by recognition that ‘[E]ffective CPD schemes are flexible and largely based on self-evaluation’ and the importance of the link between CPD and appraisal10. These considerations have shaped our thinking about how the GMC can add value without introducing rigidity and disproportionate burden.

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6 Amendments to the Medical Act 1983 in relation to revalidation (not yet in force) will enable the GMC to set the requirements for retaining a licence to practise. One of these requirements will be participation in CPD.
7 This existence of legislation to support revalidation means that separate statutory powers specifically relating to CPD are not required at the present time.
8 GMC, Response to our revalidation consultation, 2010, pp32-33
There have been other reports concerned with the challenge of embedding in medicine a culture of life-long commitment to personal and professional learning\textsuperscript{11}. These have recognised the risk that professional values fostered during a doctor’s 10 -15 years of education and training might atrophy during the much longer period of established practice that follows.

Government proposals have also sharpened the focus on who has responsibility for CPD. The Department of Health (England) consultation Liberating the NHS: Developing the Healthcare Workforce stated that ‘the current system lacks clarity about the responsibility for continuing professional development and this leads to underinvestment and wasted opportunities for staff to develop and respond to change….In the new NHS the responsibility for investing in the existing workforce and ensuring sustainability of specialist skills will sit where it should – with employers’\textsuperscript{12}. This view has been reinforced recently by a report from the NHS Future Forum which recommended that ’employers should prioritise the provision of CPD’\textsuperscript{13}. The Government has welcomed this recommendation, noting that the NHS Constitution commits all employers supplying NHS funded services to provide staff with personal development and access to appropriate training for their jobs\textsuperscript{14}.

Yet this current emphasis on the importance of CPD occurs in an economic climate which places considerable pressure on the resources available for CPD. This has informed our guidance to doctors as to the focus of their CPD activities and our thinking about how the guidance might be embedded in the workplace.

The roles of others

Examination of the regulatory context must recognise the roles of others in doctors’ CPD.

Primary responsibility for remaining up to date and fit to practise rests with the individual professional. But, as we have seen, employers have a responsibility to support doctors in this. The medical Royal Colleges and Faculties, trade bodies, professional associations and others also support their members by operating CPD schemes, producing guidance for their members and providing CPD. The AoMRC has done much to introduce a common approach to the recording, organisation and quality assurance of CPD schemes across the different specialties\textsuperscript{15}.

In medicine there is both a culture of CPD participation and an infrastructure to support it. This necessarily affects the nature of the regulatory interventions required. We need to make sure that we add value and do not duplicate or usurp work that is carried out more appropriately and effectively by others. This is what the Council for Healthcare Regulatory Excellence refers to as ‘right-touch regulation’\textsuperscript{16}.

\textsuperscript{12}Department of Health (England), Liberating the NHS: Developing the healthcare workforce, December 2010, p24
\textsuperscript{15}See Academy of Medical Royal Colleges, Ten Principles for College/Faculty CPD Schemes and Guidelines for recommended headings under which to describe a College or Faculty CPD scheme
\textsuperscript{16}Council for Healthcare Regulatory Excellence, Right Touch Regulation, August 2010
Section 6: Understanding the needs of others

35 An unpublished 2010 survey of doctors about the content of *GMC Today* showed that CPD was the area of the GMC’s work in which doctors were most interested. This indicated an opportunity for us both to add value and satisfy an unmet need.

GMC stakeholder seminar

36 Our stakeholder seminar on 30 March 2011 (see paragraph 15 above) helped us to understand how we might begin to meet that need. The key messages were:

- CPD should be directed towards improving the care provided for patients and the delivery of the service.

- Doctors should be encouraged to take responsibility for their own learning.

- Reflection drives change in performance and is the key to good CPD.

- The GMC should take a light touch, setting a framework of high level principles supported by clear guidance.

- The GMC should avoid micro-management of doctors’ CPD and duplication of the work of others.

- Annual appraisal in the workplace is central to the identification of doctors’ CPD needs and to monitoring the effectiveness of CPD activity.

- There is a need for more advice on the use of CPD in appraisal.

- Revalidation will make doctors more accountable for their CPD activity, but it must not reduce CPD to a tick-box exercise.

- It is important to recognise that some aspects of CPD can be valuable even if their outcomes are difficult to measure.

- The GMC should sign-post CPD that might be relevant for doctors.

- Consideration should be given to the needs of doctors in less than full time practice and those returning to medical practice.

- Research was required on how CPD (or the lack of it) is linked to poor performance and concerns with fitness to practise.

37 These themes are reflected in the draft CPD guidance that the working group has developed.
GMC online survey

38 Some of the messages from the seminar have been reinforced by the results of our online survey of doctors (see paragraph 17 above). As this was not a scientific study of doctors’ views we must be cautious about what we infer from the responses received.

39 Nevertheless, among the 1,872 respondents there was a clear view that primary responsibility for doctors’ professional development rests with doctors themselves (86%). 81% of respondents said they had the opportunity to discuss their CPD needs and personal development at appraisal, but that this was not necessarily followed up. For many there were concerns about the quality and effectiveness of appraisal at the present time.

40 Encouragingly, 79% of respondents said that their CPD activity over the last five years had helped to improve the quality of the service or care given to their patients. Feedback on what CPD activities had influenced or changed practice yielded a wide range of responses. This points to the importance of flexibility in the way CPD activities are understood and regulated. Responses also highlighted the value for many doctors of learning undertaken with other members of the healthcare team and with peers.

41 In terms of the GMC’s role, doctors saw value in the development of high level principles and guidance, but did not want detailed or prescriptive requirements imposed on them. Many saw a role for the GMC in working with employers to support access to CPD. This was a particular concern for SAS grade doctors and those in part-time practice. Not surprisingly, many wanted clarity about the CPD requirements for revalidation.

42 Many of these themes are covered by our proposed guidance.

43 A more detailed account of the survey results is on our website at http://www.gmc-uk.org/education/continuing_professional_development/review.asp.

Effectiveness of CPD report

44 The study commissioned by the GMC and AoMRC into the effectiveness of CPD has provided important insights into our future regulatory role and some helpful notes of caution.

45 The report looks at how doctors view their learning or the learning of others within their organisations, how this relates to conceptions of CPD, its provision and uptake, and what constitutes effective CPD.
The report shows a culture in which doctors participating in the study viewed CPD as a natural part of professional life, necessary for patient safety and rewarding17. There is no single, correct way of doing CPD18 but it was seen as more likely to be effective when doctors were able to determine their own learning needs through reflection within the totally of their practice. There was a tension between the value of informal, opportunistic learning that happens on the job and the demands for increasing accountability for CPD activity and the quantification of learning20.

There was a perceived danger that the tick-box method evoked a feeling of “being regulated” and that this in turn fostered an autopilot response to attain the “credit rating” rather than a reflective learning experience that led to a deeper and more enriched understanding of practice21.

This was neatly encapsulated in the fear of revalidation leading to the ‘industrialisation of CPD...failing to capture many individual’s learning needs”22. Since CPD aims to improve the care provided for patients, it is imperative that this does not happen.

Lessons from other regulators

We spoke to a range of regulators and other bodies in the UK about their approaches to CPD23. We also reviewed the systems operated by medical regulators worldwide. A summary of the approaches considered is at Appendix D. A detailed report on international models is on the GMC’s website at http://www.gmc-uk.org/education/continuing_professional_development/review.asp.

How CPD is regulated varies widely and it is likely to be shaped by a range of different factors. These include the underlying culture of the profession, the nature and complexity of the regulated activity, history and societal expectations, the purpose of the regulatory intervention (to ensure compliance or foster excellence, or both), the regulatory risk to be addressed and the extent to which CPD serves as a proxy for revalidation. Just as there is no single, right way of doing CPD, so there is no single right way of regulating it.

In the next section we look at the feedback we have received and what the learning from other regulatory models should mean for our role.

18 Ibid p 20
19 Ibid p 9.
20 Ibid p 41
21 Ibid p 41
22 Ibid pa 57

23 General Dental Council, Nursing and Midwifery Council, Health Professions Council, Solicitors Regulation Authority, General Teaching Council for England, Bar Standards Board, Royal Institute of British Architects, Institute of Chartered Accountants of England and Wales. We also reviewed the approaches to CPD of each of the other UK health regulators through the information on their websites.
Section 7: The role of the GMC

50 In defining our role we first needed to understand what it is we are trying to regulate and why.

51 The definition of CPD which we offered in section 2 (paragraph 8) makes clear that CPD is not simply a matter of courses and conferences. It covers ‘all learning activities, both formal and informal, by which doctors keep up to date’.

52 The definition also emphasises that CPD is not an end in itself. Its purpose is to help improve the safety and quality of care provided for patients and the public. It is therefore linked to doctors’ performance as individuals and as members of teams in the organisations where they work.

Supporting the purpose of CPD: some notes of caution for the regulator

53 It is a truism that CPD is about individual development. Professional regulation seeks to promote good practice. It does so by setting standards and requirements, defining outcomes, measuring compliance and taking action in cases of non-compliance. Our first challenge is to ensure that our regulatory tools do not distort professional development in a way which undermines the goal of enhancing patient care.

54 What we have learned from our seminars, surveys and research is that for many doctors the most effective CPD is the sort of experiential learning that occurs naturally in the workplace, almost as a by-product of practice, rather than through activities formally designated as CPD.

Inevitably, this ‘informal’ CPD activity is hard to measure and resistant to providing the sort of assurances a regulator might seek.

55 Measuring the effect on performance is even more elusive. For this reason, many regulatory models tend to record activity rather than impact on practice. Typically, they require the accumulation of CPD hours over a specified period. These models are helpful in professions where there is no established culture of CPD because the regulator can audit a sample of CPD returns to monitor basic compliance, although these may say little about the CPD’s effect on a practitioner’s actual performance. Counting CPD hours or credits may also be relevant where there are no intermediate structures between the regulator and regulated practitioner which support the CPD.

56 In medicine, those structures do exist, for example through the work of the medical Royal Colleges and Faculties (which require members to undertake 250 hours CPD over five years) and professional associations, through the role of annual appraisal, job planning and doctors’ personal development plans. Above all, revalidation will give the GMC an insight into doctors’ performance which makes our detailed scrutiny of the level of individual CPD activity superfluous.
Regulatory models differ in the extent to which they are prescriptive about the CPD professionals must undertake. The GDC, for example, currently requires dentists to undertake a minimum of 250 hours’ CPD across a five year cycle, of which 75 hours must be verifiable by the regulator. The verifiable CPD should include medical emergencies, disinfection and decontamination, radiography and radiation protection. Failure to comply results in removal from the GDC’s register. In the USA several jurisdictions take a similar approach for doctors. California requires all physicians and surgeons to ‘complete mandatory continuing education in the subjects of pain management and the treatment of the terminally ill and dying patients’. Our working group did not favour such approaches. Although prescriptive regulatory models provide certainty for the practitioner and the public, medicine is too diverse, and the regulator too far from the coal face of actual practice, to be able to determine what CPD is most relevant for each doctor and for the service within which he or she works. There would be a real risk of diverting doctors’ energies and resources from more valuable learning simply to comply with regulatory requirements.

The working group was clear that the CPD needs of individual doctors are best determined by the doctors themselves in discussion with their colleagues, teams and the service within which they work. The effective use of job planning, annual appraisal and personal development plans should be central to this. The role of the GMC is to provide a framework of principles and guidance within which those discussions should take place.

The role of revalidation

Revalidation is fundamental to our regulation of CPD, but it is important that doctors do not regard it as the impetus for, or the goal of, their CPD. An individual’s CPD must be directed towards improving and maintaining practice. Revalidation is simply a by-product of that process.

The clear message from the GMC’s 2010 revalidation consultation, The Way Forward, was the need to simplify the model. Doctors will do what is necessary for them to get through revalidation, but the GMC must ensure that revalidation does not drive doctors towards a level of minimum compliance which adds no developmental value, only regulatory burden. Clear principles and guidance around CPD from the GMC, rather than detailed and prescriptive requirements, will support this.

Revalidation will also serve the important function of enabling the GMC to look at doctors’ performance rather than at the CPD which contributes to performance. If a doctor is practising to appropriate professional standards there is no need for GMC regulatory scrutiny of the CPD input into that performance. Such scrutiny is more appropriate locally in the context of workplace annual appraisal.

References:

14 Continuing Professional Development (CPD) for Dentists, General Dental Council, December 2009.
15 American Medical Association, State Medical and Licensure Requirements and Statistics 2006
Quality assurance and accreditation of CPD

63 We have considered whether the GMC should quality assure CPD provision or accredit specific courses, events or providers. It was suggested to us that the GMC should quality assure CPD in the same way that we quality assure undergraduate medical education and postgraduate training. The working group concluded that we should not do so.

64 As this report has already noted, the most effective CPD activity is often the sort of informal, experiential learning that occurs in the workplace in the normal course of medical practice and which is least susceptible to measurement.

65 Quality assuring or accrediting more ‘formal’ CPD – that is structured courses or programmes – would inevitably result in the creation of preferred providers and preferred types of activity even though the activities themselves may be the least relevant to the individual. The resource implications are also likely to be formidable.

66 We also noted that whereas undergraduate and postgraduate training have set curricula or outcomes that everyone must meet and there is clear organisational responsibility for delivery and accountability to the GMC, this is not the case with CPD where doctors’ needs are more individualised. It is unclear what we would be quality assuring.

67 If the GMC is to be satisfied about high standards of medical practice (to which CPD is an important contributor) it is more relevant to look at the outputs of revalidation and the systems which will support it. Plans for the quality assurance and audit of revalidation are being developed. Within this work, the GMC will continue to engage with the systems regulators to ensure that organisations have in place systems which will support access to appropriate CPD for doctors.

68 Above all, the working group was mindful that, in contrast to our powers to regulate undergraduate education and postgraduate training, the GMC has no statutory powers to regulate employing or contracting organisations or the providers of CPD. We do not think the GMC should seek such powers and, at the present time, it is unlikely they could be secured.

69 We have therefore concluded that it must be a doctor’s responsibility to ensure that their CPD activities are relevant, effective and provide good value for money.
Should the GMC provide CPD?

70 The working group considered whether the GMC should be a provider of CPD for doctors. We noted, for example, that the *Good Medical Practice in Action* interactive case studies on our website offer something that looks very much like CPD. These provide the opportunity for users to apply the principles of *Good Medical Practice* to real life scenarios. We have particular expertise in this area that makes it appropriate for us to provide learning materials. We should be alive to other similar areas where our unique position will enable us to add value.

71 However, we considered that such examples are likely to be rare. In general, others will be better placed and have more relevant specialist expertise to provide CPD, and it is more appropriate that they should do this. Nevertheless, we are of the view that the GMC does have a role in drawing to doctors’ notice key developments which may be relevant to their learning needs. We discuss this further in section 8 below which looks at where we can add value.

Section 8: Adding regulatory value

GMC guidance on CPD

72 One of the required outputs from this review was a new set of GMC guidance for doctors on CPD. The draft guidance is available on our website.

73 The guidance reflects the learning described in sections 6 and 7 of this report. In particular, this includes the need for the GMC to establish a framework of principles and behaviours to guide doctors in the way they organise their CPD rather than attempt to prescribe or micro-manage their individual activity. The guidance will provide online links to a range of organisations, tools and examples of good practice which should help doctors to manage their CPD effectively.

74 The guidance makes clear that doctors have a professional responsibility to identify and act on their individual CPD needs. But because CPD is aimed at improving the safety and quality of care provided for patients and the public, this must take account of the needs of the teams and organisations within which doctors work, and the needs of their patients and of the wider community.

75 The guidance recognises the importance of flexibility in what is treated as CPD and in how CPD needs are met. One size, one learning method, one curriculum, will not fit all.
The guidance also highlights the importance of planning. Although doctors need to be alert to the unexpected opportunities for learning that arise from their day to day practice, learning cannot be left to happenstance. Good Medical Practice requires doctors to reflect on their standards of medical practice. This includes reflecting on their learning needs and how they are to be addressed. Such reflection is key to good CPD outcomes. We highlight the importance of appraisal, job planning and personal development plans in this process.

Reflection is fundamental to evaluating the impact of CPD. The guidance suggests how the use of evidence, reflection and evaluation, and commitment to practice change as part of the learning cycle, are more likely to lead to changes in behaviour.

**Equality and diversity issues arising from the guidance**

The working group considered the position of doctors who are in less than full-time practice or who are planning, or returning from, a career break. We are clear that patients and the public have a right to expect that all licensed doctors remain up to date in all areas of their work, regardless of the circumstances of their practice. Doctors therefore need to take advice from their college, their employer and others to support them in this.

Our guidance also highlights the responsibilities of employers, contracting organisations and managers to ensure that all members of their workforce have the opportunity to maintain and develop their skills, including groups who sometimes struggle to access the resources that will support their CPD, such as sessional GPs, locums and staff grade doctors. Embedding our guidance in local processes and appraisal systems will help to reinforce this message.

By taking a flexible approach in our guidance to what constitutes CPD we have tried to ensure that those who may have less ready access to formal modes of CPD are nevertheless able to have their informal activities acknowledged.

As explained in paragraphs 86-92 below, we also see opportunities for the GMC to use its unique position to bring to doctors’ attention issues that may be relevant for their CPD. Particularly for doctors who are not part of a college, specialty or professional association network, this will provide another means of helping them to reflect on their CPD needs.

Some of those we spoke with during the course of our review felt the GMC should require Colleges, employers and others to provide resources for, or access to, the CPD they required. The GMC has no regulatory jurisdiction over other organisations and we cannot compel other organisations to follow GMC guidance. Nor can we require doctors to be members of those organisations or follow the standards that they set. However, our guidance to doctors sets out where we consider that others have a responsibility to support doctors in meeting their CPD needs. In the next section we consider what steps the GMC should take to embed its guidance in the practice of others.

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http://www.gmc-uk.org/guidance/case_studies.asp
Embedding CPD in the practice of others

Our guidance will only be effective if it is successfully embedded in the way doctors approach their CPD and in the way CPD is supported by organisations and medical managers, including Responsible Officers. The guidance makes specific links to appraisal and personal development plans so as to embed our CPD principles in workplace processes. It also makes reference to the roles of others in supporting doctors’ CPD. We note, for example, that the Responsible Officer Regulations impose a statutory duty on Responsible Officers to cooperate with the GMC in relation to the GMC’s revalidation functions. The GMC should reinforce this by setting out its expectations on CPD in its guidance to Responsible Officers. Links should also be made through the Responsible Officer guidance issued by the Health Departments and through the documentation being developed in England by the Revalidation Support Team.

Some of those with whom we spoke wished us to go further and specify the nature of the CPD provision that Colleges, employers and others must make, particularly in relation to resources for, and access to, CPD. However, the working group was clear that the GMC has no legal power to impose requirements on other organisations in relation to CPD. It was also clear about the need to recognise the boundaries between the role of the regulator and that of employers, Colleges and other providers of CPD.

Sharing what we know

In paragraph 81 we state that the GMC should not, in general, be a provider of CPD. Nor should we attempt to prescribe the CPD that individual doctors must undertake. The GMC should, however, do more to use its unique position and relationship with doctors to help them identify areas of learning which may be relevant to them.

Until recently the GMC held very little information about either individual doctors or trends across the profession as a whole. That is changing. For example, our fitness to practise procedures provide a wealth of data which help us to identify trends and potential areas of regulatory risk. Research tells us that doctors pose a higher regulatory risk at key transition points in their careers. We also have research which highlights issues with prescribing errors, not just among trainees, but across all grades.

We publish this sort of information on our website, but might do more to follow it up in ways which would encourage individuals or groups of doctors to reflect further on their own practice and their own particular CPD needs.27

27 In The state of medical education and practice in the UK 2011 report published in September 2011, the GMC began the process of drawing upon the wide range of information it holds to provide a picture of today’s medical profession and some of the key challenges it faces. The aim of the report is to initiate discussion about these challenges with professional bodies, patient groups, employers, educators, other regulators, and doctors themselves.
For example, we know that international medical graduates are more likely to face challenges in making the cultural transitions necessary for UK medical practice. We have a responsibility to promote the sort of good practice which will help these transitions. At present, international medical graduates receive a copy of *Good Medical Practice* when they register and are then left, by the GMC at least, to get on with things. The current review of the PLAB test will look at this. But the GMC should do more to minimise the known regulatory risks by highlighting areas where reflection might be valuable. This is not to usurp the responsibilities of employers to provide suitable induction and support. However, the involvement of the regulator in drawing attention to the issues among relevant groups may provide impetus for action where that is needed.

During our work we saw a number of reports of concerns about deficiencies in medical expertise in particular areas of practice. Where these relate to specialties and where doctors are linked to colleges or other specialist networks there are established mechanisms through which they can access the learning they need. Yet we saw examples of groups (notably locums, doctors on career breaks and those working part-time) who reported difficulty in accessing CPD. We also learned of rapidly developing fields of practice, such as genomic medicine, which are not specialty specific and with which doctors in all types of practice will increasingly need to become familiar.

The GMC would not have the expertise to provide CPD in such areas, nor should it. However, the working group considered that the GMC should use its unique and authoritative position to highlight the importance of particular developments in medical practice or wider issues of professionalism. Particularly for doctors who are not part of a college, specialist association or other network, or who may be professionally isolated, the GMC is in a position to help them make the link to the information they need.

Revalidation will, over time, give the GMC much richer information about individual doctors than ever before. The GMC will know about their scope of practice; their specialty; grade; the stage they have reached in their career, whether they are new to UK medical practice or returning to practice. The working group noted that it may, in future, be possible for the GMC to use its unique database to make connections with individual doctors or groups of doctors by targeting information likely to be relevant for their professional development.

This would be a significant step for the regulator to take. The GMC would need to consider carefully any data protection and other legal implications. It would also need to be clear that its role was not to dictate the content of doctors’ CPD activity, but to facilitate doctors’ access to relevant learning or facilitate reflection on whether that learning would be useful. Doctors have told us that they are interested in receiving more information from the GMC about CPD. This would be a step towards meeting that need.
Section 9: Further work

This report sets out recommendations for the GMC’s future role in regulating doctors’ CPD. But it is not the final word. The healthcare landscape is constantly changing and the GMC’s role in CPD will need to reflect developments.

Future changes to the shape of postgraduate training and in technology may affect the way in which doctors need to develop their knowledge and skills once they have completed formal training and how those new skills need to be assured by the GMC. Other initiatives, such as the credentialing of medical practice outside of training may also require the GMC to update the way it regulates.

The GMC must also ensure that its approach continues to reflect research in the field, particularly the links between CPD and performance. The GMC should, for example, be able to use the learning from ongoing research to guide the sort of regulatory interventions discussed in paragraphs 86-92.

Despite the inevitability of further change, the working group considered that the principles set out in this report, and particularly in the guidance, provide a good basis for the future regulation of CPD.

Section 10: Conclusions and recommendations

In 2010 the GMC assumed responsibility for regulating the continuum of medical education and training. The way in which it does this must reflect the different nature of doctors’ education and training needs at different stages of their careers.

Once doctors have completed their formal postgraduate training their needs, the needs of their patients and of the service within which they work will be particular to the circumstances of their practice. The diversity of medical practice means there is no CPD curriculum for all doctors to follow.

The GMC requires all licensed doctors to participate in CPD in order to maintain and improve the standards of their practice. Doctors do so because they recognise that this is integral to their professionalism and their duty to their patients and the public. What CPD activities will be appropriate must be for doctors themselves to determine having regard to the needs of their patients and the service in which they work. Revalidation will show that they are doing so effectively. The task for the regulator, working with others, is to provide a CPD framework which helps them to do this effectively.
Recommendation 1: The GMC must provide a framework of principles and guidance to support doctors in planning, undertaking and evaluating their CPD activities [paragraphs 36, 41, 46, 53-59].

Recommendation 2: The effective use of job planning, annual appraisal and personal development plans should be central to the identification, content and evaluation of doctors’ CPD needs [paragraphs 36, 56, 59, 62].

Recommendation 3: The GMC should endorse the principles and guidance provided at Appendix 5 to this report [paragraphs 72-77].

Recommendation 4: The GMC should work with the systems regulators, accountable employers’ organisations, the Health Departments and NHS Revalidation Support Team to embed its CPD guidance in local processes of appraisal and personal development planning [paragraphs 83-85].

Recommendation 5: The GMC’s revalidation guidance to Responsible Officers should highlight the relevance of our CPD guidance [paragraph 83].

Recommendation 6: The GMC should not quality assure or accredit CPD provision. Instead, its focus should be on the outputs of doctors’ revalidation, to which CPD is an input [paragraphs 63-69].

Recommendation 7: The GMC should explore how it might bring to doctors’ attention developments in medical practice or professionalism which may be relevant to their CPD. It will be for doctors to determine how those issues affect their practice and whether they should be addressed through their CPD [paragraphs 86-92].

Recommendation 8: The GMC should not, in general, be a provider of CPD for doctors except in those discrete areas where its unique position as the regulator enables it to add value [paragraphs 70-71].

Recommendation 9: The GMC should commission research on how CPD (or the lack of it) is linked to poor performance and concerns with fitness to practise [paragraphs 36, 95].
Appendix A: Terms of reference

Background

1 Under section 5 of the Medical Act 1983 the GMC has the 'general function of promoting high standards of medical education and coordinating all stages of medical education'.

2 Good Medical Practice requires doctors to keep their knowledge and skills up to date throughout their working lives.

3 In 2004 the GMC published the guidance booklet Continuing Professional Development which made explicit ways in which doctors might identify their learning needs and undertake their professional obligation to keep up to date.

4 Since 2004, much has changed. The merger of PMETB with the GMC has caused us to look across the continuum of medical education and training and to consider our role at each stage. This includes consideration of how we fulfil our objective of ensuring proper standards in the practice of medicine once a doctor’s formal training is complete. Progress towards the introduction of revalidation has placed greater emphasis on doctors’ CPD activity as a means of demonstrating that they remain up to date and fit to practise throughout their careers. At the same time, the economic downturn is putting greater pressure on the resources available to support doctors’ CPD activities.

5 These and other developments make it necessary to update our 2004 guidance. In doing so we also need to look more broadly at the role of the regulator in relation to CPD. This was one of the conclusions of Lord Patel’s 2010 report setting out recommendations and options for the future regulation of education and training. Lord Patel recommended:

‘GMC should update its 2004 CPD guidance and re-examine how the regulatory role in CPD should be exercised so as to support doctors in meeting the requirements of revalidation and providing high quality care for their patients, whilst preserving the value of CPD for individual professionals.’

6 At its meeting on 13 July 2010 the Council of the GMC accepted this recommendation.

7 A review of the GMC’s role in CPD will follow the terms of reference set out below.

Purpose

8 To examine and make recommendations on the GMC’s role in CPD.
Themes and issues for the review

Theme 1: understanding the terrain – what other regulators do

9 The examination of the appropriate role for the GMC will be informed by a review of the respective regulatory approaches to CPD taken by other UK regulators and by medical regulators in other jurisdictions. This will include looking at how CDP activity is assured and how it fits within their wider regulatory regime.

b the sufficiency of the CPD principles and criteria that were the subject of the GMC’s 2010 revalidation consultation

c the proper relationship between College CPD requirements and the requirements for revalidation

d how the transparency and accountability of CPD is assured through appraisal.

Theme 2: understanding the terrain – the role of the medical royal colleges and the AoMRC, and the responsibility of individual doctors

10 The review will consider the role of the medical royal colleges and faculties and of the AoMRC as the setters of the principles and standards for, and as providers of, CPD. In doing so consideration will also be given to the provision and recognition of CPD outside of the College systems and how groups of doctors who are not members of Colleges are able to access quality CPD.

11 The review will also consider CPD as part of the professionalism of individual doctors and how it might be supported by employers.

Theme 3: quality, consistency and improving medical practice

12 The review will consider what steps the GMC should take to ensure the quality and consistency of CPD. Issues will include:

a the CPD’s contribution both to improved medical practice generally and specifically revalidation

Theme 4: CPD and regulatory risk

13 The review will consider the role of CPD in helping to address areas of regulatory risk, such as moments of career transition, entry onto the GP or specialist registers or entry into UK medical practice by non-UK medical graduates. Issues will include:

a feedback loops from the GMC’s work on standards and fitness to practise and from research

b whether there is a role for the GMC as a promoter or provider of CPD

c whether the GMC has a role in supporting the CPD needs of particular groups who may not otherwise be sufficiently served by existing arrangements.

Theme 5: legislation and guidance

14 In the light of conclusions reached, the working group will make recommendations as to whether the GMC should seek specific statutory powers in respect of the regulation of CPD and/or update the GMC’s 2004 CPD guidance.
Outputs

15 The outputs of the review will be:

a a report to the Continued Practice Board setting out recommendations for the role of the GMC in CPD

b following consultation on the report and draft guidance, an updated version of the GMC's 2004 CPD guidance.

Process: review membership

16 The review will be undertaken by a working group drawn from members of Council and representatives from bodies relevant to CPD issues as listed below:

a working group chair appointed by the GMC’s Continued Practice, Revalidation and Registration Board

b not more than three additional members of Council

c one representative from the Academy of Medical Royal Colleges Directors of CPD Group

d one representative from NHS Employers

e one representative from the postgraduate deaneries

f one representative from the Directors of Postgraduate General Practice Education.

17 The group may seek information and expertise from additional sources, as required.

Working methods

18 The work of the review will be taken forward through meetings of the group and by email, as required.

19 It will be for the group to identify what material it requires to support its work, such as discussion papers, research, surveys, questionnaires or focus groups.

Accountability

20 The review group will report to the Continued Practice Board of the GMC.

Timescales

21 The intention is for the group to submit its report and draft CPD guidance first to the Continued Practice Board of the GMC by May 2011 and then to Council.
Appendix B: Working principles for the review

1 The aim of the following principles is to help the group identify what a successful outcome for the review might look like so that the soundness of our final recommendations can later be tested against the principles.

a CPD is a means to an end and not an end in itself. The regulation of CPD should be directed towards achieving improved performance and better patient care.

b All doctors have a professional duty to keep their knowledge and skills up to date and regularly participate in activities that maintain and further develop their competence and performance.

c The role of the GMC is to be flexible, facilitative and supportive. We should support doctors in identifying and participating in the CPD most relevant to them and to their healthcare organisations.

d CPD should be tailored to the needs of the individual. Our role should recognise the individual nature of doctors’ CPD needs.

e The GMC’s approach to the regulation of CPD should recognise personal reflection, appraisal and PDPs as the principle local mechanisms for evaluating and monitoring the CPD of individuals.

f Regulation must avoid imposing detailed and prescriptive requirements for CPD which risk diverting doctors’ CPD activity from their own professional needs, the needs of the organisations in which they work and the needs of their patients. However, this should not preclude the GMC from working with the specialties and others to identify developments in medical practice which may assist doctors in identifying their needs.

g There must be national standards for CPD, but local delivery of those standards. The GMC should define the overarching principles governing CPD and set national standards. However, it is for doctors in consultation with their employers (or those who contract their services) and colleagues to determine their individual CPD needs having regard to those standards, the circumstances of their practice and the needs of their patients.

h In setting the standards for CPD the GMC must provide sufficient clarity for doctors, and those appraising them, to know what is needed to meet the requirements of revalidation.

i The GMC must work with others (including the Colleges and employers) to support the participation in CPD of all non-training grade doctors.

j The GMC should not be involved in the delivery of CPD.
Appendix C: Working group membership

Mrs Suzanne McCarthy (Chair) – GMC lay member
Dr John Jenkins – GMC medical member
Professor Trudie Roberts – GMC medical member
Dr Mairi Scott – GMC medical member
Dr Claire Loughrey – Director of GP Postgraduate Education, Northern Ireland
Professor Alistair Thompson – Chair, Academy of Medical Royal Colleges Directors of CPD Committee
Mr Bill McMillan – NHS Employers
Dr Ian Starke – Vice Chair, Academy of Medical Royal Colleges Directors of CPD Committee, deputising for Professor Thompson
Appendix D: Models for regulating CPD: international perspective

Foreword
This paper presents an up to date, international perspective of continuing professional development (CPD) programmes and requirements for doctors. It draws together international academic literature, regulatory guidance, legislation and other online material from around the world to form an overview of CPD that is far wider in scope, and more detailed, than other published studies.

Whether a legal obligation or an unregulated voluntary option, doctors in almost every country undertake some form of CPD. This paper considers CPD systems in a wide range of countries, from Japan and Kenya, to Ireland and Canada. Some, such as Pakistan, are taking their first steps towards establishing a national CPD programme. Others, like the USA, which began granting CME recognition awards to doctors over forty years ago, have a long history of CPD.28

The paper has involved extensive primary research in order to capture as current a picture of CPD as is possible. CPD systems evolve and change very quickly, which means that the information in published research can swiftly go out of date and cease to be factual. The only reliable sources of the latest data are the documentation from the regulatory bodies and professional medical societies, which can often be located online. Unfortunately but understandably, websites and documentation are often not provided in English.

Relevant information has been translated from French and German, and where possible, attempts have been made to translate information written in other languages. However, a comprehensible overview of a country’s CPD system can, on occasion, remain tantalisingly hidden behind a language barrier. The current CPD systems in Russia and South America are examples of this and, regrettably, details of the CPD schemes of these areas could not be verified.

Despite such obstacles, this examination of almost thirty countries’ CPD systems should serve to provide a full and fairly comprehensive global account of the way regulatory bodies, professional medical societies, and doctors are utilising CPD.

Search methodology
The search was conducted using research databases and facilities at the General Medical Council, the Royal Society of Medicine Library and the British Library in London.

To locate published studies on CPD in the medical sector, a specific search syntax of CPD/CME and free-text terms associated with CPD, doctors, revalidation, recertification and international comparisons was applied across: Medline, EBSCO Academic Search Complete, Science Direct, Web of Science, Ingenta Connect, Project Muse, Cochrane Reviews and Social Science Citation Index.

Studies which were deemed irrelevant were removed during the study selection process. Forty-two relevant studies were selected from the literature database search and were annotated. Countries with clearly defined or unique CPD schemes were pinpointed. A search of websites was undertaken, using Google, Google Scholar and other search engines to determine whether information in the published literature was up to date.

It became apparent that much material was out of date, and so searches of regulatory bodies, medical societies and government websites were undertaken to attempt to locate up to date guidance and legislative information. Google and other search engines were used to locate such material.

Working on a country-by-country basis, a log of CPD systems around the world was built. Forty-seven countries were eventually searched, but information of relevance could only be gleaned from twenty-seven countries. Detailed research of these twenty-seven countries was undertaken. Relevant material in French, German and Spanish documentation was translated.

Another specific search syntax of [country name] and free-text terms associated with CPD, doctors, revalidation, recertification and international comparisons was applied across the research databases listed above was applied, to ensure no published literature had been missed in the initial search.

A note on CPD/CME terminology

The term CPD acknowledges the wide-ranging competencies needed to practice high quality medicine, including medical, managerial, ethical, social and personal skills. CPD therefore incorporates the concept of CME, which generally is taken to refer only to expanding the knowledge and skill base required by doctors. 29

Although Continuing Professional Development and Continuing Medical Education can be, and are frequently used interchangeably, most literature has now defined CME as being an ingredient of CPD. As one academic has put it, 'CPD is a process that includes continuing medical education'. 30 Many countries are now moving from a ‘knowledge and skills base’ CME system, towards a system that seeks to promote the ‘the wide-ranging competencies needed to practice high quality medicine’ that CPD entails.

This research paper has not attempted to stipulate which countries’ systems may or may not constitute CME or CPD, but has followed the terminology each individual country uses to refer to its own systems.


Introduction

Few published studies have provided a comprehensive overview or comparison of CPD systems, either in Europe or internationally. In 2003, the European Union of Medical Specialties released a paper which summarised, very briefly, CME/CPD systems in its member countries. A few years later there came the publication of three studies, which still remain fairly prominent and widely cited. An article by Merkur et al (2008), whilst ostensibly focusing on revalidation, provided a concise outline of CPD in a number of European countries, including Germany, the Netherlands, Austria, Belgium, France and Spain. In 2009, a comparative analysis of CME in six European countries, written by Garattini et al, emerged which provided additional details of CPD in Norway and Italy. In the same year, Euro Observer published a collection of articles which again examined the CPD systems in Austria, France Germany, albeit in more detail.

Whilst such research is to be welcomed and has informed this paper, studies have, arguably, either repeatedly focused on the CPD systems in a small number of countries, or provided a concise review of others. In setting out to answer the following questions (below), this research paper attempts to bridge the gap, by providing a solid outline of CPD systems around the world, and, where relevant, more detailed accounts of these systems.

Research questions

1. Do other countries have or are they developing standards, guidelines or criteria on the use of CPD as a way for doctors to stay up to date? How detailed or prescriptive are the criteria? What kind of obligations do doctors have in following these guidelines and are there consequences if they do not?

2. In what way are other medical regulators ensuring that their doctors are undertaking CPD? How, if indeed they do, are they auditing individual doctors’ CPD activities? Does the regulator accredit or quality assure CPD activity, or provide CPD for doctors? What other bodies may undertake this role?

3. Are any of these jurisdictions developing or have developed a revalidation process? How does CPD fit into that process? Are there any emerging trends in the use of CPD in revalidation?

4. Are there any examples of regulators helping doctors identify areas where CPD may be useful through a facilitative or engagement role? For example, do they guide doctors towards, or direct or require particular types of CPD activity?
Do other countries have or are they developing standards, guidelines or criteria on the use of CPD as a way for doctors to stay up to date? How detailed or prescriptive are the criteria? What kind of obligations do doctors have in following these guidelines and are there consequences if they do not? Do regulators guide doctors towards, or direct or require particular types of CPD activity?

There have been several key changes to CPD systems recently. As of May 2011, it became compulsory for all doctors in Ireland to participate in a CPD scheme. In July 2010, sweeping regulatory changes in Australia brought about mandatory CPD for doctors. Provinces in Canada are in the process of rolling out compulsory CPD for doctors, which is also the case in Malaysia. Indeed, of the 22 countries in this study which require doctors to participate in CPD, over half have adopted the mandatory policy since 2001. It would seem that many governments and regulatory bodies are moving away from systems of voluntary CPD, although voluntary professional CPD processes exist in Belgium, Spain and Sweden.

Almost all the regulatory bodies in countries where CPD is mandatory have developed standards and guidelines on the use of CPD. Some, such as the Medical Council Ireland’s guidance on CPD set out the standards behind the CPD scheme – such as good medical practice – but only stipulate basic requirements: ‘as a minimum, doctors have to engage in fifty hours of CPD and one clinical audit per year.’ Others go much further. The Medical Council of New Zealand has issued some of the most detailed and unique CPD guidance, which requires non-specialist doctors to form collegial relationships, take part in CME, clinical audit and peer review. The Council also stipulates exactly how many hours must be spent on each of these activities.

Most regulatory bodies, at the very least, set the minimum number of credits doctors should gain (or hours doctors must spend) on CPD each year in order to fulfil requirements. It is worth noting that there is no international, standardised system of using CPD credits and although most countries, as a rule of thumb, award 1 credit for 1 hour of CPD activity, countries can award different amounts of credits for undertaking the same pursuit (e.g. publishing a research paper). The number of credits needed varies, even within particular countries. For example, in the USA, the State Medical Board of Kansas asks for 50 credits per year, whilst the State Medical Board of Alabama currently only asks for 12 credits. The highest number of credits required for CPD that this study uncovered is 80, in Canada. Whilst CPD is voluntary in Sweden, doctors are encouraged to spend ten days per year participating in CPD activities. At the other end of the scale is Kenya, where only five CPD credits – equivalent to five CPD hours – are required per year.

In various countries where CPD is mandatory, doctors must take part in particular CPD programmes. In Canada, provinces are beginning to require doctors to enrol in a choice of two CPD programmes, one run by the Royal College of Physicians and Surgeons of Canada, the other by the College of Family Physicians of Canada. In New Zealand, specialists must enrol and participate in a CPD programme run by their specialist association. Whilst the State Medical Boards in the USA where CME is compulsory do not specify that doctors participate in a specific CME programme, the type of activities which doctors can claim CME credits

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31 Of the countries not covered in this report, Saudi Arabia, UAE, Brazil, Argentina and Mexico have mandatory CPD. Nigeria, Turkey, Israel, Philippines, Thailand, Costa Rica and Peru have professional CPD.

32 It should be noted that some countries in Europe have redesigned their CPD schemes to match the UEMS EACCME framework of CME credits.

for is sometimes dictated and usually only formally accredited CME activities can be used toward CME credit.

Occasionally, regulatory bodies specify the subject matter for CPD, or the type of CPD that must be undertaken. In Slovakia, doctors must ensure that 60% of their CPD credits are earned through participating in or attending officially accredited medical education event (the remainder can be accrued through personal study). Specialists in Germany have to show that 70% of their vocational training has been on topics concerning their specialty. In Singapore, this figure is 20%. South African doctors must gain five credits per year (out a total of thirty) by studying subjects relating to ethics, human rights or medical law.

Are there consequences if doctors do no participate in CPD?

The consequences for non-compliance of compulsory CPD vary throughout the world and range in severity. Where CPD is linked to recertification or re-registration, the law often gives regulatory bodies the option to revoke the licences of non-compliant doctors, but locating evidence of whether or not this actually occurs – and to what extent – can be difficult.

Despite the requirement for compulsory CPD being part of legislation, the lack of robust regulatory frameworks in some countries makes it difficult for the law to be applied. For example, in Greece and Jamaica (and previously France) despite a mandatory system, there would appear to be no penalty for doctors who do not participate in CPD. In Greece this is because there is no agreed or formal system of certifying participants. Therefore, whilst the Greek Minister of Health lawfully has the right to revoke the licence of a doctor who does not accrue 100 hours of CPD each year, there is actually no way for the Minister to know which doctor has or has not fulfilled their obligation.

South Africa and the Netherlands have taken the decision to allow non-compliant doctors extra time to fulfil their requirements, as opposed to immediately imposing penalties. South African non-compliant doctors are given up to a year to accrue any outstanding CME points before they are referred to the Medical Board. Doctors who fail to fulfil their CPD requirements in some provinces in Canada are provided with a mentor, who will actively help the doctor accrue CPD credits. More serious consequences, such as revocation of a licence, are used as a last resort. In Croatia and Singapore, a number of doctors have indeed had their licences revoked, and have had to re-sit an examination (Croatia) or fulfil their CME requirements (Singapore) in order to gain their licences back. In Hungary, non-compliance can result in doctors losing their specialist status. The State Medical Board in Texas has the option to publicly reprimand and fine a doctor up to $500 should they fail to fulfil their CME obligations.

Though not necessarily a sanction, doctors in some countries may lose out financially through non-participation in CPD programmes. In Norway, specialist GPs who take part in the compulsory CPD scheme are able to increase their fees by 20%; those who are non-compliant may lose their specialist status, but also face losing the significant monetary benefits that come with participation. The system of CPD is entirely voluntary in Belgium, but because participation in it is linked to increased fees and one-off payments, over a three year period, doctors who participate in the voluntary scheme can end up earning almost €15,000. Unsurprisingly, this has resulted in around eight out of every ten doctors engaging in CPD.
In what way are other medical regulators ensuring that their doctors are undertaking CPD? How, if indeed they do, are they auditing individual doctors’ CPD activities?

As the CPD Institute has pointed out, ‘monitoring and compliance are the most difficult aspects of implementing CPD policy…In particular professions face difficulty in…ensuring compliance across the majority of membership [and] dealing with the increased complexity of monitoring the more varied and self-managed CPD being undertaken.’

This research has uncovered that the auditing of doctors’ CPD activities is widespread, and is the main method which regulatory bodies (or equivalent) use in order to ensure (a degree of) compliance. The number of doctors audited varies from country to country. The highest audit percentage this research found will be undertaken by the Medical Council Ireland, which seems likely to audit 15% of all doctors undergoing re-licensure in 2012. The New Zealand Medical Council audits 10% of applications for recertification. In both these countries, the bodies which provide the CPD programmes, such as the specialist colleges, also audit CPD activities. The Australian and New Zealand College of Anaesthetists, for example, audits 5% of all doctors who complete their three-year CPD programme. Such ‘double auditing’ appears to be fairly common. Toward the other end of the scale is the Medical Council in Slovenia, which audits approximately 2.5% of CPD declarations.

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In most countries, doctors who are audited are required to submit evidence of CPD activities to the relevant authority. This will usually consist of a CPD portfolio together with certificates of CME events – from conferences, for example – which provide evidence of attendance. For non-specialist doctors in New Zealand, all documents must be countersigned by a colleague, but this is unique.

Because of the audit schemes, doctors are therefore required to keep all CPD evidence for a number of years. In Canada, doctors have to retain a personal copy of proof of participation in a CPD scheme for a minimum period of six years in case they are selected to participate in audit. Many countries also require that the providers of CME also keep copies of event registers, so that doctors’ attendance can be corroborated. In Singapore, CME providers are required to keep hard copies of registers for a minimum period of two years, in South Africa three years, and in the USA, documentation setting out the credit awarded for certified activities must be kept by providers for a minimum of six years after the completion date of the activity.

Does the regulator accredit or quality assure CPD activity, or provide CPD for doctors? What other bodies may undertake this role?

There is extensive accreditation of CPD activities and providers. The Austrian Medical Chamber runs its own CPD programme, although this is uncommon. A few regulatory bodies, such as the Regional Chambers in Germany, the Medical Board of Doctors in South Africa and the National Institute in Belgium directly accredit CME events.
Most regulators delegate the responsibility of the running of CPD schemes to professional medical societies, such as specialist colleges, which then accredit CPD events themselves. Regulatory bodies tend to accredit the societies which provide CPD programmes and require CPD programme providers to meet a set of rules. In Australia, the Australian Medical Council (AMC) runs a very strict and active accreditation scheme for CPD programme providers, during which AMC expert assessment teams travel to the medical association to examine its CPD programme against standards set by the Council. In the USA, the Accreditation Council for Continuing Medical Education (ACCME) is responsible for accrediting organisations which provide CME. It has a particularly lengthy accreditation process, which involves visits, interviews and two separate decision-making committees. Many State Medical Boards require CME activities to be ACCME accredited.

Are any of these jurisdictions developing or have developed a revalidation process? How does CPD fit into that process? Are there any emerging trends in the use of CPD in revalidation?

A number of countries have made the participation of CPD a condition for recertification. In order to re-register, GPs in the Netherlands must recertify every five years, in which time they must have performed clinical work for a minimum number of hours, undertaken at least 40 hours of CPD per year and taken part in at least two hours of peer review per year. In Norway, Specialist GPs must undergo re-certification every five years and CME requirements form part of the re-certification process. A mandatory six year re-certification cycle which is directly linked to CPD exists in Croatia. Doctors in New Zealand must apply for an Annual Practising Certificate (APC) each year, in order to practise medicine. The issuance of an APC is entirely dependent on the doctor declaring that they have taken part in a CPD programme, and providing proof of this if audited.

A number of CPD schemes are linked to re-registration. In order for doctors in Australia to re-register each year, they must affirm that they are participating in a CPD programme, and must provide proof of this if audited. This is a similar system to that in Ireland where doctors seeking to renew their professional registration are required to complete an annual declaration that they have enrolled in and are complying with the requirements of a specific competence scheme.

The Medical Council of Singapore has indicated that it is moving toward a system of revalidation. Perhaps most significantly, the Federation of State Medical Boards in the USA has released a new framework for maintenance of licensure rules, which should come into being in April 2012. If this system becomes mandatory, as looks likely, doctors would be legally mandated to participate in a ‘more robust program of continuous professional development that is relevant to their areas of practice, measured against objective data sources and aimed at improving performance over time.’

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34 http://www.cpdinstitute.org/storage/pdfs/CPD_Research.pdf
35 http://www.fsmb.org/mol.html
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<th>Credits / Year</th>
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Annex B

Draft continuing professional development guidance for consultation
Responsibility for personal learning
You are responsible for identifying your CPD needs, planning how those needs should be addressed and undertaking CPD that will support your professional development and practice.

Reflection
*Good Medical Practice* requires you to reflect regularly on your standards of medical practice.

Scope of practice
You must remain competent and up to date in all areas of your practice.

Individual and team learning
Your CPD activity should aim to maintain and improve the standards of your own practice and also that of any teams within which you work.

Identification of needs
Your CPD activities should be shaped by assessment of your professional needs and the needs of the service and the people who use it.

Outcomes
You must reflect on what you have learned through your CPD and record any impact (or expected future impact) on your performance and practice.
Introduction

What is CPD?
1. Continuing professional development (CPD) refers to any learning that you take part in outside undergraduate education and postgraduate training which helps you maintain and improve your performance. It covers the development of your knowledge, skills, attitudes and behaviours across all areas of your medical practice. It includes all learning activities, both formal and informal, by which you maintain and develop the quality of your professional work.

Why CPD is important for doctors
2. What you learnt at medical school and during postgraduate training must be updated throughout your career to reflect changes in practice, the needs of the service and changes in society’s expectations of the way doctors work.
3. Effective CPD will help you anticipate and respond to those changing demands. It will enable you to keep up to date and fit to practise, and maintain the professional standards required of you throughout your career.
4. A summary of your CPD activity is one element of the supporting information that you will need to bring to your annual appraisal to demonstrate that you have met the requirements for revalidation.
5. In addition, taking part in relevant CPD can support specific changes in your practice and may enhance your career opportunities and work satisfaction.
6. Above all, your CPD should help you maintain and improve the quality of care you give your patients and the standards of the service in which you work.

The aims of CPD
7. CPD aims to improve doctors’ practice by affirming what is good, addressing areas requiring improvement and exploring new knowledge, skills and behaviours.

Who the guidance is for
8. This guidance is primarily for doctors and references to ‘you’ are intended for doctors. It may also be of use and of interest to employers, representatives of doctors, patients and the public.

Doctors
9. The guidance explains what the General Medical Council (GMC) expects you to do to maintain and improve your practice through CPD. It will help you understand and meet the CPD requirements for revalidation.

Organisations
10. Employers and those contracting doctors’ services have a responsibility to make sure their workforce is up to date and practising to the appropriate standards. Doctors will be better able to maintain those standards in organisations which foster a culture of learning. This guidance will help everyone involved in developing the practice of individual doctors to understand what we, as the regulator, expect of their medical workforce so they can support doctors in meeting our standards.
Patients and the public
11 The guidance will also help patients and members of the public to understand what we expect doctors to do in order to stay up to date and improve the safety and quality of care they provide.

Regulatory context
12 The GMC has a statutory duty to promote high standards of medical education. This includes the CPD of doctors once they have completed their undergraduate medical education and postgraduate training.

13 Our core guidance for the medical profession, *Good Medical Practice* (2006), sets out the principles and values on which good practice is founded and which we believe make a good doctor. It places a duty on you to keep your knowledge and skills up to date throughout your working life by regularly taking part in activities that maintain and further develop your competence and performance.

14 This guidance explains how you should fulfil that duty. Revalidation will confirm that you are doing so effectively.

How the guidance applies to you
15 This guidance covers planning, carrying out and evaluating your CPD. It also explains how CPD will work within revalidation. It does not tell you what CPD opportunities, or how much CPD, is right for you. You will need to judge how best to apply the principles of this guidance to your own practice and professional development.

16 In the guidance the terms 'you must' and 'you should' are used in the following ways.

- 'You must' is used for an overriding duty or requirement.

- 'You should' is used when we are providing an explanation of how you will meet the overriding duty.

- 'You should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can comply with the guidance.

17 CPD is about both maintaining and improving your medical practice. This guidance sets out approaches to CPD which all doctors should be able to follow.

18 In this guidance the term 'practice' includes all the professional roles that you perform currently and those that you plan to perform.
Planning your CPD

19 The purpose of CPD is to help improve the safety and quality of care provided by you and the teams in which you work. This goal should guide your thinking about your learning and development needs.

Responsibility for personal learning

20 You are responsible for identifying your CPD needs, planning how those needs should be addressed and undertaking CPD that is relevant to your practice and will support your professional development.

21 You must remain up to date and competent in all of the work that you do. This includes both the clinical and non-clinical aspects of your practice and any management, research and teaching or training responsibilities that you may have. Your CPD activities will help you do this.

22 Your CPD activities should also support potential changes and developments to your professional roles throughout your career. CPD should prepare you to deal with the changing nature of medical practice and the development of the teams and the services in which you work.

23 Not all CPD opportunities will be planned. You should be alert to opportunities for informal learning and reflection that arise spontaneously from your day to day practice. This can be one of the most fruitful forms of CPD because it links directly to your everyday work.

Planning your CPD to meet the needs of others

24 You must consider how you can support the needs of your teams, the organisations in which you work and the needs of your patients and the wider community.

25 How you divide your CPD activities across the different areas of your work will depend on your assessment of your needs in particular areas, the needs of your patients (if you treat patients) and the needs of the service. While it may be possible to identify these needs for yourself, it is important that you regularly discuss and agree them with your manager and appraiser.

26 You should therefore ask for, and be receptive to, ideas that others may have for your learning and development. Your annual appraisal or job planning discussion along with agreement of your Personal Development Plan (PDP) will help you to identify and address your needs and those of others.

27 Your medical director, manager or clinical lead may be able to give you advice about CPD activities that will help you to support improvements in the workplace or the quality of care in your organisation. Discussions with colleagues, patients or those who use your services may also highlight opportunities for improvement in your practice or ways in which your CPD activities could support the learning and development of your team as a whole and help provide a better service.

1 Schostak J, Hanson J, Schostak J, Brown T, Driscoll P, Starke I, Jenkins N, The Effectiveness of Continuing Professional Development, College of Emergency Medicine, 2010

Also World Federation for Medical Education, Continuing Professional Development (CPD) of Medical Doctors: WFME Global Standards for Quality Improvement, WFME Office, University of Copenhagen, Denmark, 2003, p 7.

Moon J. A. Reflection in learning and professional development: theory and practice, 1999

GMP(2006), paragraph 14(b)
You should be prepared to review your PDP throughout the year in the light of these discussions to ensure that it remains relevant to your needs. Planning and evaluating your CPD needs and opportunities should be managed not just at appraisal, but on an ongoing basis.

**Reflecting on your practice**

Reflection on practice drives change in performance and is the key to effective CPD. Good Medical Practice requires you to reflect regularly on your standards of medical practice.

You must reflect on all aspects of your professional work. This should be informed by discussion with others and by specific evidence, such as data from audit, service improvement, complaints and compliments, significant events, workplace based assessments and feedback from patients and colleagues. This will help you identify your learning and development needs, which you should then agree with your manager (if you have one) and appraiser.

You must also reflect on what you have learnt from the CPD activities you have undertaken and record whether or not there has been any impact (or expected future impact) on your performance and practice. This will help you assess whether your learning is adding value to the care of your patients and improving the service in which you practice.

Reflection must be integral to your PDP and your appraisal discussion.

**The learning cycle**

Once you have identified a learning need you should find out more about the issue and what learning opportunities are available. You should then analyse and reflect on the information you have found, consider how the learning may influence your performance and decide whether and, if so, how you can integrate the learning within your practice. After taking part in CPD, you should evaluate and reflect on the impact of each activity and consider any further learning needs.

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Carrying out your continuing professional development

Content of your CPD activities

34 You must remain competent and up to date in all areas of your professional practice.

35 The content of your CPD is for you to determine in discussion with your manager (if you have one), educational supervisor (if you have one) and appraiser. The resulting PDP will influence many of your learning objectives. Unless you have given specific undertakings to the GMC, or had conditions attached to your registration as a result of involvement in our fitness to practise procedures, the GMC will not prescribe the CPD activities you should take part in.

36 From time to time, the GMC may identify and publicise issues which we believe may be relevant to the CPD of all doctors or to particular groups of doctors. This might relate, for example, to particular developments in medical practice, to wider issues of professionalism arising from our research and regulatory activity or to relevant legislative changes. It will be up to you to determine whether those issues are relevant to your own practice and whether they should be addressed through your CPD.

37 The Good Medical Practice Framework for appraisal and revalidation may provide a structure for discussing your CPD during appraisal. You do not have to map all of your CPD against the Framework, but your CPD activities should take account of the domains and attributes set out in the Framework. The domains are:

- knowledge, skills and performance
- safety and quality
- communication, partnership and teamwork
- maintaining trust.

38 Although we will not specify what learning you must undertake, you should be prepared to look for developmental opportunities across all four domains and not confine your learning to those areas of your practice where you feel most comfortable.
Organising your CPD

39 There is no single correct way of ‘doing CPD’. How you meet your learning needs will depend on your own preferred ways of learning, what you are trying to learn and the opportunities available to you. You should, however, seek a variety of learning activities that allow you to learn in different ways. This is because there is evidence that undertaking a range of different CPD activities aimed at addressing a particular learning need is likely to be more effective than one-off events.

40 Your CPD should be a mix of formal and informal learning and should include activities which take place locally where you work as well as at regional, national or international levels.

41 Some of your learning should be aimed at improving the effectiveness of your team as a whole and its contribution to the organisation in which it is based. CPD focused on the effectiveness of a team should be undertaken alongside team colleagues.

42 You should also participate in peer-based learning such as peer reviews, peer-tutoring and learning within specialty networks in order to stay up to date with changes in your specialty. Discussing and disseminating your learning to others may help consolidate your own learning and enhance that of the team.

43 You should discuss with your manager, appraiser, educational supervisor or the CPD lead in your workplace (as appropriate) how best to meet your particular learning needs and the support available to help you do this.

Amount of CPD

44 It is your responsibility to undertake sufficient, appropriate CPD in order to remain up to date and fit to practise in the work that you do and to be able to demonstrate this at your annual appraisal. This applies whether you are in full time or less than full time practice.

45 Most medical royal colleges and faculties have developed CPD schemes or guidance to support doctors in keeping up to date and in maintaining and developing their professional standards in their specialty. The colleges and faculties may require doctors participating in these schemes to obtain a specified number of CPD credits over a five year period.

46 We do not require you to be a member of a college or faculty CPD scheme, undertake a specific number of hours of CPD each year or acquire a particular number of CPD credits. However, you may find that participating in such a scheme is helpful both in keeping current and in being able to demonstrate on an ongoing basis that you are practising to the appropriate standards in your specialty. Even if you are not a member of a formal CPD scheme, you will still need to show your manager (if you have one) and appraiser how you are keeping up to date and following recognised best practice in your field or specialty.
Career breaks

47 If you are considering taking a break from medical practice, or are already doing so, you should discuss with your college, faculty, postgraduate deanery, employing organisation or appraiser what steps you might need to take to remain up to date in your specialty while you are away. You should also take advice on any support you will need to assist your return to practice in due course.

48 If you maintain your licence to practise while on a career break, you will be expected to keep up to date and participate in revalidation. In order to revalidate, you will be required to show that you have carried out appropriate CPD. Further information about revalidation and career breaks can be found at http://www.gmc-uk.org/doctors/revalidation/faq_revalidation_p4.asp#10

CPD as supporting information for revalidation

49 Revalidation is the process through which doctors demonstrate periodically that they are up to date and fit to practise. It is the means by which you can show you have been taking part in CPD that is appropriate for the work that you do. Revalidation may also be a lever to help you discuss your developmental needs.

50 In order to revalidate you will need to participate in an annual appraisal covering the whole of your practice.

51 Participation in CPD will be one type of supporting information you will need to discuss at your appraisal to show that you are keeping up to date and working to enhance the quality of your practice.

52 Your appraiser will want to know what you think the supporting information says about your practice and how you may intend to develop or change your practice as a result.

53 The GMC does not prescribe any specific CPD activities that you must take part in for revalidation, but you must consider the advice in this guidance and follow recognised best practice for CPD in your field or specialty. If you are not clear about the CPD that is appropriate for your work, you should discuss this with your manager (if you have one) and your appraiser.

54 You can find further information about revalidation in the GMC guidance booklets Good Medical Practice Framework for appraisal and revalidation and Supporting information for appraisal and revalidation. http://www.gmc-uk.org/doctors/revalidation/9569.asp In addition, the medical Royal Colleges and Faculties have developed specialty specific guidance for their members on revalidation that includes advice on CPD.
Evaluating the impact of your CPD

It will often not be possible to measure directly the effect of a particular CPD activity in terms of improved patient outcomes. The fact that you cannot readily measure this effect should not diminish the value of the activity. However, you must try to identify ways in which your CPD activity may help improve the quality of care provided for your patients and the public.

You should use the evidence from your practice, research, audit and other quality improvement information to reflect accurately on your performance and that of your team. You should then commit to making any necessary improvements to your own and your team’s practice as part of your professional development. In due course you should reflect on whether your CPD activities have helped you to meet your objectives and, if not, whether any further learning or other activities are needed. Research suggests that commitment to improving performance in this way is more likely to lead to changes in behaviour.

When considering the outcome of your learning, you may find it helpful to reflect on the following questions.

Knowledge of practice

- Have you identified learning priorities based on your practice?
- Are you developing and monitoring your learning needs and opportunities on an ongoing basis?

Scanning the environment

- Are you able to identify learning opportunities and to integrate this learning into your performance and practice?

Managing your knowledge in practice

- Have you used a PDP to manage your CPD planning, participation, reflection and impact?
- Have you gathered evidence of your CPD activities and recorded the impact of your learning?
Raising and answering questions

- Are you able to raise a question about or set objectives for your practice or performance, seek evidence, come to a conclusion about the question and demonstrate how this may impact on your practice or performance or meet your learning goals (the learning cycle)?

- Are you able to analyse, reflect on and connect your learning to your standards of medical practice? Have you considered how your learning and experience of your learning may be improved and used to plan future goals?

Practice assessment

- Have you identified and are you able to use a range of tools and processes such as audit, colleague and patient feedback and review of significant events to identify areas for improvement or development in performance?

Recording CPD activity

58 Keeping a record of your learning needs, your learning and its outcomes is part of the learning process. It will help you validate your learning and support discussions with your appraiser, employer or others about your learning needs.

59 Even if the learning has been informal and has arisen directly from events in the workplace it is important to document what you have learned. This will assist with your appraisal discussion and your revalidation.

60 There is a range of organisations, including the medical royal colleges and faculties, specialist associations and professional trade bodies that may be able to help you manage your CPD using an online portfolio or other similar tools.

61 We will not normally ask to see details of your CPD activity. However, Good Medical Practice requires you to be honest and trustworthy and act with integrity. You must therefore make sure that you record your CPD activity fully and accurately.

Ensuring quality and value

62 You are responsible for making sure that your CPD activities are relevant, effective and provide good value for money.

63 Some organisations accredit events and activities for CPD. For information about CPD accreditation and quality assurance of specific CPD activities you should contact the CPD provider, your medical royal college or faculty, specialist association, postgraduate deanery or CPD lead.

64 We do not endorse or accredit particular CPD activities. We do not give CPD points or credits for learning activities and we do not hold lists of CPD providers.
The role of others

65 Although this guidance is focused primarily on your responsibility as a professional to keep up to date through CPD, others have a role in helping you do this.

The GMC

66 Our role is to set out the framework of principles and behaviours that should guide doctors’ CPD activity. Where appropriate, we will also raise awareness about trends, issues or opportunities which may be relevant to doctors’ CPD.

Employers and contractors of doctors’ services

67 Employers and contractors of doctors’ services have a responsibility to ensure that their workforce is competent, up to date and able to meet the needs of the service. It is in their interests to maintain and develop the professional skills of all of their medical staff whether they are consultants, staff grade, specialty or associate specialist doctors, sessional GPs, locums or trainees, and to facilitate access to the resources (including the time to learn) that will support this.

68 Employers and contractors should use the system of annual appraisal alongside job planning and PDPs to identify the CPD needs of their staff, to discuss how best those needs should be met and to monitor the effectiveness of doctors’ CPD activity.

69 Doctors will be better able to maintain and improve their performance where organisations have both a culture of learning and information systems which allow doctors to measure their outcomes and the quality of care they provide.

Responsible officers and medical managers

70 Doctors with managerial responsibilities should do their best to make sure that the individuals and teams they manage are able to fulfil their professional duties so that standards of practice and care are maintained and improved. They should make sure that their teams are appropriately supported and developed and are clear about their objectives. Medical managers should support the staff they manage to complete the learning and development activities identified by appraisal and performance review.

71 Doctors who are Responsible Officers within a designated organisation will have additional responsibilities set out in statutory regulations and must have regard to any guidance produced by the UK health departments for their organisation.

Systems regulators

72 Organisations such as the Care Quality Commission in England, the Health Inspectorate Wales, the Regulation and Quality Improvement Authority in Northern Ireland and Healthcare Improvement Scotland have responsibilities for overseeing the quality of care provided by organisations across the UK. This includes ensuring that organisations have in place arrangements for staff to obtain appropriate training, professional development, supervision and appraisal so that they are able to deliver care and treatment to an appropriate standard.
Medical royal colleges, specialist associations and other professional organisations

73 Medical royal colleges, faculties, specialist associations and professional trade bodies are some of the principal providers of CPD.

74 All medical royal colleges and faculties have published guidance on how CPD in their specialty should be carried out. A majority of medical royal colleges and faculties also have formal CPD schemes that are based on the Academy of Medical Royal Colleges’ document, *Ten Principles of College/Faculty CPD Schemes*. These schemes provide a range of tools and advice to help you record and manage your CPD effectively and guidance on professional standards within a specialty. Many colleges and faculties have accreditation and approval systems in place that consider the educational quality of the CPD activities they approve.

Help for doctors

75 Medical schools, higher education institutions, professional trade bodies and other organisations also provide a range of helpful courses and learning materials.

76 Some of the key organisations involved in CPD and some suggested further reading are provided at Appendix A.

77 We have identified examples of innovative or notable practice for CPD. You can find these on our website [These will be identified through the consultation and ongoing research].
Appendix A

There are many organisations that may assist you with your CPD as well as further reading that you may find helpful. A selection of these is provided below: [Links will be provided when guidance is published after consultation]

Academy of Medical Royal Colleges
List of Royal Medical Colleges
Royal Society of Medicine
European Union of Medical Specialists
British Medical Association
NHS Employers

Further reading

The Academy of Medical Royal Colleges (http://www.rcgp.org.uk/professional_development/continuing_professional_devt/cpd_key_documents.aspx) has produced a number of useful documents including:

- Reflective guidance and template
- The Ten Principles for College/ Faculty CPD Schemes
- CPD model
- The Return to Practice guidance
- Guidance on accreditation.

The Royal College of GPs has produced a guide on personal development plans (PDP): PDP guidance by RCGP

NHS Employers and the BMA have issued joint guidance on job planning (http://www.bma.org.uk/employmentandcontracts/working_arrangements/job_planning/jobplanningforconsultantsengland.jsp).

The Department of Health (England) has guidance for Responsible Officers


Annex C

Summary of responses from our survey on the role of the GMC in CPD March to August 2011
As part of the review we held an informal survey for doctors to get a snapshot of how they use CPD and their views on the role the GMC should play in supporting doctors’ CPD activities.

**Overall outcome of survey**
- Respondents: 1,975
  - 52% of responses from consultants
  - 16% of responses from SAS doctors
  - 10% of responses from GPs
  - 10% of responses from trainees
  - 83% of responses came from doctors in full time work
  - 17% of responses came from doctors in part time work.

When asked what the GMC’s role in CPD should be, the top four choices (doctors could choose more than one answer) were:
- working with employers to encourage access to CPD (20%)
- describing what CPD is needed to meet the requirements for revalidation (19.4%)
- setting high level principles, national standards and guidance (17%)
- helping doctors identify areas of CPD that may be relevant to them (14%)
- only 3.5% indicated that the GMC should not be involved in CPD at all.
Some respondents made additional comments about the role of the GMC. Overall, these comments suggested the GMC should take a high level role in CPD and the details should be left to the colleges. There was a general concern the GMC may make guidance and CPD requirements too prescriptive. However, there was also strong support for the GMC to set a minimum standard for CPD in terms of quality. Most respondents supported a role for the GMC to work with employers to help doctors get access to CPD. This was particular relevant for SAS doctors.

- ‘Ticking boxes and jumping through hoops does not make a good doctor. Self development does. The GMC should adopt a role of facilitating and promoting this concept.’

- ‘Many of the other roles mentioned above are provided by the colleges and should continue to do so. GMC need to work with the colleges.’

- ‘GMC should work with employers and make CPD sessions as mandatory and part of the weekly job plan for SAS doctors, as most of the trusts are service orientated and getting a single session of CPD is sometime difficult for the SAS doctor. Even I have done work at times during my CPD time to meet the service demands. The only solution to all this issue is personal involvement of GMC in CPD activity.’

- ‘My own view is that the GMC should be setting general principles and more importantly emphasising the need for CPD through making it a requirement of revalidation. It should do this in conjunction with employers to assure access by individuals to CPD particularly to local meetings.’

- ‘The GMC should state unambiguously that Royal Colleges should not become de facto sole accreditors of CPD providers or content – particularly where they also provide CPD content courses themselves, since this may lead to a monopoly of CPD provision and is a clear conflict of interest (especially if they then charge for both accreditation of providers and provision of their own courses etc).’

- ‘The royal colleges are best placed to advise on CPD for the specialties. Other CPD though is currently being mandated by Employers, Deaneries, private hospitals etc and this needs reigning in as it is unachievable if doctors straddle all of these. Mandatory training required by Trusts, deaneries and private hospitals could be prescribed by the GMC to give uniformity and standards.’

- ‘I think there must be some generic advice and requirements from the GMC about CPD, as there must be some core requirements. Also since some doctors have portfolio careers or work part-time there will be some issues regarding how much is requires and also how much in each role. clearly employers have a vested interest insofar as they will lose staff who are not revalidated, but each employer would probably want the CPD to be covered/funded by another employer.’
‘The GMC should only have a very broad role – the details should be decided by colleges and similar “expert” bodies. However the GMC should direct employers to make facilities eg funding/time off available for CPD’.

‘1. CPD approval for a meeting can be from a range of approved providers and the resultant educational quality delivered through many meetings is very variable. Often one feels that the content is more for the presenter’s or provider’s benefit rather than the attender’s. Valuable learning points I, and many colleagues, find to be few and far between. I have not ticked the box for the GMC themselves to quality assure but their role in the process needs to be strong.
2. Particular attention needs to be paid to the proper management of CPD as required for revalidation in respect of part-time/locum/part-retiree doctors. Full timers will have this through their employers (which needs to be mandated) but difficult for the others unless undertaken on a perhaps regional basis.’

‘Doctors are quite capable of self directed learning. Stop wasting our money.’

‘Perhaps the GMC could help ensure that doctors their staff and other colleagues are able to learn together. The deaneries require teamwork in primary care. There is a shortfall of interdisciplinary education and its practical application’

**Primary responsibility for CPD**

When asked if doctors are primarily responsible for their own professional development across all areas of their practice:

- 86% of respondents agreed
- 14% of respondents disagreed or were not sure.

Overall, comments supporting this question suggested that doctors are professionals and therefore must be accountable for ensuring they are competent and up to date. Where respondents disagreed or were not sure about their responsibility, they either indicated it was the responsibility of their employer or suggested a combination of individual and employer responsibility. Again, there was concern over access and time to do CPD.

- ‘I do not believe there is a better “profession” than doctors at keeping themselves up to date. Bring in some sort of compulsory element and we risk losing this “professionalism”. It will become a matter of ticking boxes, and when completed will foster the idea of “I’m ok, why do more”. Self development has and will produce better doctors. However, there is nothing wrong with helping doctors to identify what they need to develop, we are sometimes not aware of how to identify...what we don’t know we don’t know.’
‘It has to be self motivated but it must also be informed by appraisal discussions to ensure that areas of weakness are addressed rather than the constant reinforcement of existing good practice. Employers need to be assured that CPD is used to address any issues that they may have about a doctor’s knowledge, skill or behaviours and robust appraisal should be able to address this in a supportive and formative way.’

‘Part of what being a professional is about, take it away at your peril’.

‘With reflection and insight and being a professional a doctor should be able to decide what CPD they require to develop and be aware of gaps in their knowledge or skills’.

‘I think both me and the hospital that I work at both of us are responsible for my professional development. My responsibility to be always able to achieve the highest standards in medicine and responsibility of hospital that I work at is to give me training courses and involve me in educational programs that help me to achieve that’.

Access to CPD activities

When asked if doctors were able to access CPD activities necessary for their role and to help them improve and develop their professional practice:

- 78% indicated they were able to access appropriate learning
- 22% indicated they were unable to access or were not sure.

Overall, most comments suggested that learning activities are accessible to some extent but often the learning is limited or one sided. For example, doctors in rural areas may struggle to get peer based CPD. Many doctors indicated that they accessed CPD but had to arrange and pay for it out of their own pocket and on their own time. This seems to be especially true for locums. Many comments focused on the lack of or difficulty getting funding for larger/national CPD activities and often felt limited to local or free CPD, which was not necessarily appropriate for their specialty. There was also real concern that the current financial situation in the NHS would further limit access to CPD. There is also some suggestion that the amount of CPD activities and opportunities leads to confusion on what is necessary and of value.

- ‘If a doctor lives near a big city there isn’t a problem but for anybody living in more rural areas CPD offers are rather one sided. Organisations like the BMA or royal colleges invariably set up stuff in London which is a reason among others why I feel estranged from them. Attending is expensive requiring transport and accommodation and very time consuming.’
- ‘It is in my own time and as a locum is at the expense of either family life or paid work.’
‘Yes I do, but the best source is high – quality conferences and funding is limited, requiring substantial personal contribution. This is not right, especially in specialties with little or no private practice. I can readily access CPD points free – but these are of limited relevance to keeping up to date in my clinical specialty and therefore not of great value in this respect. Time availability for study leave is getting much tighter than previously.’

‘These days there is plenty of good quality CPD available (at least for General Physicians). The problem is deciding what not to read/attend. The Hospital Trust has always been very supportive.’

‘Working in a senior and service orientated post, sometimes it is difficult to maintain CPD activity. I try my best to preserve CPD time for some teaching, audit or some personal reading in the library. we have a shortage of medical staff. This is another reason for not able to utilise CPD time for CPD activity, sometime. My consultant is very supportive for my CPD. I have no SPA time during the week. I only have one CPD session a week. I have started teaching non medical prescribers during my CPD time. I personally think that SAS doctors should be given more sessions of SPA and CPD time similar to consultants.’

‘I have anxieties about my ability to have the time available to participate in CPD in the current productivity driven NHS. Employers do not seem to understand the importance of interactive or face to face activities in professional development.’

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**CPD in appraisal**

When asked if doctors have an opportunity to discuss CPD needs and personal development as part of the appraisal process:

- 81% said yes
- 12% said no
- 7% were not sure.

Generally, doctors indicated that they discussed CPD at their appraisals but it was often in a broad sense and was not necessarily followed up. Most respondents saw value in embedding CPD in the appraisal process. However, a significant number of comments raised concerns about the quality and effectiveness of their appraisal system in general. Many saw revalidation as the impetus for improving appraisals. Trainees seem to have had the best outcomes for development from their appraisals.

- ‘Appraisal is an excellent opportunity to identify and discuss personal needs. Unfortunately it is still not being practised in the way it should. Guidance and performance standards along with surveillance mechanisms can ensure good appraisal systems through GMC.’

- ‘Not in any depth or of much value.’

- ‘An extremely important component of appraisal, and one of the hopeful benefits of strengthened medical appraisal is that this area will be better dealt with by the trained appraiser assessing supporting information, seeing what is missing and helping the appraisee see certain areas that may be needed for CPD the individual cannot see themselves.’
‘But it’s partly only lip-service to development needs – it carries no weight in my Trust, and very little managerial interest. No-one’s interested in a great doctor, just one good enough to do an average job without noticeable mistakes.’

‘My appraiser can’t really assess the relevance of particular CPD as he isn’t from my subspecialty – he just has to take my word for it. Plus my appraiser has no ‘power’ to get the Trust/dept to give me the time/funding.’

‘BUT time constraints in General Practice – no Slack. Really I could do with going to medical school again for three months to get up to date with recent pathophysiology and subject lectures, but this is never going to happen – we have nothing to sell unlike British Airways who can build in training costs into the ticket price.’

**CPD that improved practice**

When asked if doctors think that their CPD activity over the last five years helped to improve the quality of service provide or the care given to your patients:

- 79% said yes
- 6% said no
- 15% said not sure.

We also asked doctors to feedback what activities have influenced or changed their practice the most. Unsurprisingly, examples given were wide and varied ranging from national conferences, e-learning, local courses and advice and support from colleagues and peers. The variety of responses seems to support a flexible approach to CPD based on individual needs and preferences. There were also quite a lot of examples where doctors valued learning done with team and peers. Many doctors also identified value in reflecting on their learning and performance.

- ‘Educational update courses with networking with colleagues. Reflective practice is good but sporadic. Online activities not quite as good.’

- ‘General medical updates with specialists highlighting important recent changes in practice. Even just attending internal grand rounds I get reminders about certain less common conditions or new style of practice. Specialist interest group meetings have also helped my management of Parkinsons patients.’
‘Local leadership course – being a better clinical lead in developing the unit I work in. Sim faculty training – using human patient simulation training to develop doctors using technical and non – technical skills and crisis resource management to improve safety. College conference – sharing ideas and looking at what’s new.’

‘1. Local interaction with colleagues in the team, both formally via our weekly meetings and informally, stimulate accessing and acting on new developments; 2. Reading specialist journals, and using newer online resources such as UpTo Date and Medscape. 3. Participation in national organisations which both provide CPD and set standards raises ones own CPD standards. 4. Attendance at national and international meetings remains important – getting away from the coalface is an opportunity to study and learn.’

‘1) Frequent advice about advances and handling these. 2) Reviews of current practice. 3) Teaching others of the field.’

‘Increased confidence knowing other centres have similar day to day problems. Using a communication technique suggested for breaking bad news.’

We also gave respondents an opportunity to further comment. Most comments reiterated value in high level principles and a plea to not introduce more bureaucracy and even more tick – boxing. Many also reiterated concerns for funding and the potential shake up of the NHS in England.

‘The GMC is doing an excellent job.’

‘Needs to be a champion of this approach and to ensure that employers make it a high priority, and not just pay lip service to it ie CPD.’

‘Budgets for CPD and study leave need to be protected. Sponsored activities should be entirely free of influence of sponsors. Sponsored travel should be allowed to continue.’

‘Provide the framework in general terms but support the employers in getting tough on strengthening appraisal, including assessment of CPD, to reduce the self-certification/self assessment nature of the present system. It is far too easy to tick the boxes and play the game currently.’

‘I would like the GMC to have some understanding and acceptance of the difficulties of part timers undertaking the same level of CPD as those employed full time.’

‘If CPD is to be successful regarding those doctors working outside the NHS ie those employed by ATOS particularly part – time, on behalf of the government, then it needs to be brought home to the employer that they have a stake in maintaining our professional development. They cannot just transfer their responsibility to some commercial organisation which purports to provide support with the CPD process as has been suggested. It matters little to me now as I realise that experience counts for little these days and am going to retire!’
‘The royal colleges and faculties have primary responsibility for CPD. The GMC’s role should be in setting overall standards, matters related to revalidation, and filling gaps, eg for people in non-mainstream specialties for whom the work of the faculties and colleges is largely irrelevant.’

‘Lots of flexibility needed, especially in terms of high cost CPD activities. Needs and circumstances are vastly different across the profession. Especially true for locums who are not based in one department’

‘CPD should remain a professional activity not a bureaucratic exercize to soothe the anxieties of an ignorant central office. With personal reflection professionals are best placed to identify their own learning needs. Heavy handedness from GMC will increase risk by disenfrancising the profession from its own learning.’

‘The GMC should continue to lead the way in setting standards for excellence in medicine – they are a strong role model for other professions. Supporting and demanding CPD is fundamental to this function.’

‘I think the GMC should be assertive about its expectations in terms of outcomes expected from doctors in relation to CPD, the time that should be available to doctors for CPD (apart from collecting and collating audit data, VLE and reading; CPD is not something that can be done in isolation) and the responsibility of employers to facilitate both.’

‘If you ask a bunch of kids to walk along a beach and keep their feet dry, the vast majority will comply and a quick glance will be sufficient before they board the bus home. If you go to an airport everyone is treated as a potential terrorist. Which model do you want?’
Summary

There was also a general feel that doctors value and support CPD as part of their professional practice but seem cynical about the current appraisal arrangements and the value of their CPD as a measurable outcome.

Most comments suggested that the role of the GMC was to support CPD through high level guidance and principles that should not be prescriptive. However, doctors did see value in the GMC working with employers to improve the access and quality of CPD at local levels.

Many comments stressed the difficulty doctors may face from employers to access CPD resources and concern that these will become even more limited in the future.

There was a great degree of support for colleges as the bastions of specialty good practice and strong support for their involvement in the detail and quality assurance of CPD. On the margins, there was significant comment and concern about revalidation and what will happen if doctors fail to obtain appropriate CPD.
Annex D

Consultation questions
Summary of responses from our survey on

1. Do you agree that the GMC should provide a framework of principles and guidance to support doctors in their CPD rather than specifying in detail the activities a doctor must undertake? If you think we should be prescriptive please say why and in what ways.

2. Does the guidance place appropriate emphasis on doctors’ CPD activity being informed by the needs of patients and the public?

3. Does the guidance appropriately balance the CPD needs of the individual doctor and the needs of the team?

4. Does the guidance place the right emphasis on the role of appraisal and Personal Development Plans in guiding doctors’ individual CPD activities?

5. Is the guidance sufficiently clear about the responsibilities of employers and contractors in supporting doctors’ CPD activity?

6. Do you think there are any barriers stopping employers and contractors from carrying out their responsibilities?

7. Does the guidance provide sufficient information about the use of CPD to support revalidation? If not, what further information would be helpful?

8. Do you think we have identified the most effective ways of embedding the guidance into local processes?

9. Do you agree that there is a role for the GMC in bringing to doctors’ attention information about emerging trends or developments in medical practice and professionalism in order to help them reflect on their CPD needs?

10. Do you think that our proposals as a whole (the guidance, the plans for incorporating the guidance into local processes, and the proposals for bringing to doctors’ attention information which may be relevant to their CPD) will help recognition of doctors’ CPD needs?

11. Are there any groups of doctors upon whom our proposals might have an adverse effect?

12. Our report contains 9 specific recommendations on the role of the GMC in regulating doctors’ CPD. Do you have any other comments on the conclusions of the review report and the report recommendations?

13. Is there anything further we should be doing to regulate doctors’ CPD?