The legal framework

1. The general equality duty is set out in section 149(1) of the Equality Act 2010 (‘the Act’). It provides that a public authority must, in the exercise of its functions, have due regard to the need to:

   - Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
   - Advance equality of opportunity between people who share a protected characteristic and those who do not.
   - Foster good relations between people who share a protected characteristic and those who do not.

2. The GMC is listed as a public authority, with respect to its public functions, in a recent amendment to Schedule 19 to the Act.

3. The protected characteristics/equality strands defined in the Act as:

   - Age
   - Disability
   - Gender reassignment/transgender
   - Marriage and Civil Partnership
   - Pregnancy/maternity
   - Race/ethnicity
   - Religion or belief
   - Sex/gender
   - Sexual Orientation
Introduction

4. We are reviewing our regulatory role in continuing professional development (CPD). Our aim is to consult on the outcomes of the review from 17 October 2011 to 27 January 2012 and to publish the consultation results in spring 2012.

5. We published the guidance, *Continuing Professional Development* in 2004. It was developed through a GMC working group with external representative in 2002 and underwent a consultation process in 2003. The guidance made explicit for the first time the ways in which doctors might identify their learning needs and undertake their professional obligation to keep up to date. It suggested that doctors' professional development should be informed by *Good Medical Practice*. It also set out the role of other organisations, such as employers and deaneries, in helping doctors keep up to date.

6. On 9 December 2009 Council noted revalidation will require doctors to demonstrate, on a regular basis, that they remain up to date and fit to practise. Participation in CPD will be one of the ways in which doctors do this. Our 2010 revalidation consultation set out some possible principles which should inform doctors’ CPD within the context of revalidation. Generally, feedback from the revalidation consultation was supportive. The role of the regulator and the principles will be reviewed in more detail as part of the current project development.

7. Lord Patel’s 2010 report setting out recommendations and options for the future regulation of education and training 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.’

Equality analysis of our role in CPD

8. The areas of our work in CPD will be considered with regard to:

   a. The review of our role in CPD
   
   b. The evidence base for our work on CPD
   
   c. Impact on protected characteristics
   
   d. Communication, engagement and consultation

The review of our role in CPD
9. During 2011 we reviewed of our role in CPD. The review was taken forward by a small working group which brought together the GMC and key interest groups including the Academy of Medical Royal Colleges, employers, postgraduate deaneries and others.

10. The aim of the review of CPD was:
   a. To examine and make recommendations on our regulatory role in CPD.

11. Our review 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. CPD should be determined by individual needs, the needs of the organisations and teams with which doctors work, and the needs of patients and the public.

12. Our role should be to provide a framework of principles and guidance for how doctors should approach their professional development in terms of the way it is planned, carried out and evaluated.

13. We should not, however, prescribe particular CPD activities that doctors must or should undertake, or the amount of CPD required. Instead, doctors’ CPD needs should be identified, discussed and monitored locally through the doctor’s annual appraisal and decided by the needs of the individual doctor, their teams, the organisation in which they work and their patients and the wider community.


Consultation on our role in CPD

15. We are now consulting on the recommendations set out in the Final Report from 17 October 2011 to 27 January 2012. We are asking for feedback on three main areas of our work on CPD:
   a. Introduction of revised CPD guidance to provide a framework of principles to support doctors’ in planning, carrying out and evaluating their CPD.
   b. Incorporation of the CPD guidance into local processes of appraisal and personal development plans.
c. Identification and dissemination of information about key trends, developments in medical practice or professionalism which may be relevant to doctors’ future CPD needs.

**Developing the evidence base**

16. There is extensive information available on healthcare issues for diverse groups and the barriers they experience. We will use the knowledge to inform our work on CPD and to influence others such as employers and other bodies.

17. Set out below is the summary of some recent evidence obtained from the GMC’s academic research programme.

ESRC Projects – published 2009

18. *Exploring doctors’ transitions to new levels of medical responsibility* by Trudie Roberts and colleagues considered implications for the transition of trainee doctors within the workplace. They found the learning by doctors during these transitions focused almost entirely on patient-centred aspects while other learning, such as relationships with colleagues, processes and practical issues were ignored. Trainee doctors in transition tended to underperform (and expect to underperform) at the start of new clinical rotations. Although other colleagues recognised this gap in abilities, employers and regulatory bodies did not acknowledge these times of transition in their expectations of doctors’ performances. The study found that there was inconsistent monitoring and support for these doctors while they tried to integrate into their new roles and responsibilities.

19. *The experiences of UK, EU and non-EU medical graduates making the transitions to the UK workplace* by Jan Illing and colleagues explored the impact of knowledge and experience of doctors trained outside the UK on their performance within the UK healthcare system. They concluded that doctors who qualify outside the UK face difficulties in moving to the UK, many of which are practical, but some of which relate to cultural influences on their working. They constitute a more varied group than UK graduates, and, as such, may have a wider range of less predictable problems relating to their individual experiences and to the systems and cultures in which they have trained. The report suggested that, as undergraduate and postgraduate education in the UK becomes more ‘joined up’, it may have unintended consequences of making overseas doctors less aligned with the NHS when they begin work.

20. *Non-UK qualified doctors and Good Medical Practice*, the GMC commissioned the University of Warwick to explore the experience of doctors who have qualified outside the UK in working within the ethical regulatory framework of Good Medical Practice. A number of difficulties were found to be experienced by non-UK qualified doctors in their transition to practice within the UK ethical and professional regulatory framework. These included a lack of relevant information about legal, ethical and professional standards and guidance prior to registration,
variable levels of training and support specifically in the areas of communication and ethical decision making, and isolation in non-training posts. The key difference between non-UK qualifiers and UK qualifiers is the emphasis on individual autonomy and shared decision making between doctor and patient. Non-UK qualifiers lacked the tacit knowledge held by UK graduates of the context in which the law and guidance was developed.

Effectiveness of CPD

21. In 2009, the GMC and the Academy of Medical Royal Colleges commissioned research on the effectiveness of continuing professional development. The report explored how consultants understand their own learning and how this learning relates to their concept of CPD, its provision and uptake. This study found that there is a great deal of variation in the ways doctors identify effective CPD, often embedding it within their professional contexts.

Supporting doctors

22. A study commissioned by the Royal College of GPs on Revalidation processes for sessional GPs: A feasibility study to pilot current proposals by Di Jelley explored the potential problems locum, salaried and remote GPs may have with the proposed supporting information required for appraisal as part of the revalidation process. The Report found that Locums feel they are perceived to have a lower status than other GPs, and that this translates to a lack of engagement and support from practices in completing appraisal and revalidation activities. Out of hours and remote GPs also experienced isolation and felt relatively unsupported. The availability of a peer group of supportive colleagues would help the completion of supporting information requirements, by providing the opportunity for reflective discussion.

23. Research by Gill Morrow et al looking at the preparedness of specialist registrars to take on the role of consultants in 2009 found that doctors found making the transition to consultants challenging and struggled with their increased responsibilities and management and leadership roles.

International perspectives on CPD

24. We commissioned an analysis of the standards of CPD and the way they are quality assured by regulators in different jurisdictions. Overall there is a general trend towards more explicit requirements for CPD with most jurisdictions introducing mandatory CPD for their doctors, usually based on a credit/hour scheme.
Implication of CPD on performance

25. We have just commissioned a research team from Capita and the University of Sheffield to look at possible relationships between CPD and improvements in medical practice and performance. The research will develop a number of case studies that explore some of the barriers for effective CPD along with examples of good practice. It will try to get a cross section of participants from different work environments and roles. We have also asked them to explore the perception and impact of doctors CPD on the teams and if possible on patients. The research is due to complete in autumn 2012.

Impact of research on protected characteristics

26. We have identified categories of doctors for whom there are potential barriers to undertaking effective CPD. Across all of these groups, concerns have been raised that these doctors often have less opportunities and access for CPD.

Doctors who work part time

27. Research shows the majority of doctors working part time tend to be women\(^1\). For example, 30% of consultants who work part time and the majority of doctors under the age of 35 are women, many of whom may need more flexible or part time working arrangements in the future.

28. Our draft CPD guidance makes clear that doctors who work part time will be expected to undertake as much CPD as is necessary to ensure they remain competent across all areas of their practice. It cannot be the case that doctors can have less regard to maintaining and improving the standard of their practice simply because they work less than full time.

29. However, for these doctors barriers may be created if there is unequal access to CPD resources necessary for them to remain up to date. This includes time for undertaking CPD. Many doctors report they are expected to undertake their CPD outside of work hours compared to full time doctors who are given training opportunities during their work\(^2\) (although it has been argued within our working group that these constraints apply just as much to all doctors).

30. Although aware of these potential barriers, we anticipate that the flexible approach to what constitutes CPD which we have set out in our CPD guidance will allow doctors to consider a wide range of formal and informal activities within planned learning, reflection and appraisal processes. Our guidance also highlights the responsibilities of others to support all groups of doctors.

\(^1\) Women and medicine: The Future. Summary of findings from the Royal College of Physicians research, June 2009.

\(^2\) Making Part time Work, Medical Women’s Federation, 2008.
31. In discussions with SAS grade doctors for this review, and at the GMC SAS Roundtable event in May 2011, it was argued that these doctors often cover clinical shifts while trainees and consultants undertake training and CPD. They contended that equivalent developmental opportunities are more difficult for them to secure and they have reported less access to, and support for, their CPD, while also acknowledging that in England finance has been made available for SAS grades.

32. Surveys\(^3\) have found that many doctors in SAS posts have qualified outside of the UK. A number of these roles are filled by women who have chosen this career path for life/work reasons\(^4\). About one third of speciality grade doctors and one quarter of associate specialists and staff grade doctors report they used their full entitlements to study leave. The majority of SAS doctors indicated a lack of support and funding prevented them from undertaking learning and development opportunities. The same sorts of concerns are reflected in the results of our own survey for this review.

33. Similar trends have also been reported for locum doctors. Doctors working in locum posts (who tend to have less structured work environments), may struggle to undertake effective appraisals and are less likely to have access to CPD opportunities, particularly team based learning\(^5\).

34. Our review of CPD, therefore, must consider the impact of our recommendations on SAS and locum doctors, many of whom will meet the protected characteristic relating to race, religion and belief and sex. The guidance stresses that all doctors must have access and opportunities for CPD, embeds the planning and evaluation of CPD within appraisal systems and emphasises the responsibility of employers to support CPD. We intend the guidance to help doctors and employers develop effective CPD that will meet the needs of the individual, teams and organisations.

**Doctors on a career break**

35. Doctors may take a career break for a number of reasons (including maternity leave, illness or disability or to undertake research or take up academic posts). The CPD guidance suggests that doctors on career breaks should consider how they will maintain and improve their professional practice and consider how best to manage their return to practise. It emphasises a need for doctors, employers and other to plan ways prospectively to keep up to date while outside of practice.

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\(^3\) BMA Survey of SAS Doctors, 2010.

\(^4\) Women and medicine: The Future. Summary of findings from the Royal College of Physicians research, June 2009.

\(^5\) Di Jelley, Revalidation processes for sessional GPs: A feasibility study to pilot current proposals, Royal College of GPs, 2009.
36. Protected characteristics associated with age, pregnancy and maternity as well as disability must be considered for these doctors in particular. Doctors who require flexible work arrangements and career breaks may find it more difficult to access effective CPD opportunities and resources. The CPD guidance, based on reflection and flexibility, will ensure we do not impose any further barriers on these groups. It will also help these doctors to be clearer about their CPD requirements and plan their development needs effectively, regardless of their work arrangements.

**Communication, engagement, and consultation**

37. We have been talking to doctors and others about our role in CPD through a number of activities over the last two years.

*Starting the discussion about CPD*

38. Early draft principles on CPD were included in the revalidation consultation in 2010. Feedback on the principles found that 80% of respondents agreed that the principles are appropriate criteria to guide doctors’ CPD activities for revalidation. A number of respondents welcomed the development of the principles, suggesting that they will help provide focus to the planning of CPD for revalidation. Respondents commented that it was important that the principles should be applied flexibly and that we should not be overly prescriptive. One concern was that the proposed principles could be made more robust. Some respondents suggested that there should be more emphasis on the independent assessment of learning needs to ensure that it is relevant to the doctor’s job. There were also different views on the issue of participation in College and Faculty schemes.

*Early and ongoing engagement*

39. Since the revalidation consultation, we have been reviewing our role in CPD within our medical education and training function as well as the implication of revalidation.

40. 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 seminars**

41. We held a seminar for key people working on CPD within the UK on 30 March 2011. The seminar helped us to understand how we might begin to meet the needs of doctors and the service. We also included discussions about CPD within two of the Education Engagement roundtable events in May 2011 to explore the impact of our possible role in CPD including guidance on SAS doctors as well as doctors in the first years of their practice.
GMC online survey

42. Messages from the seminars were reinforced by the results of our online survey of doctors, held between March to August 2010. As this was not a scientific study of doctors’ views we must be cautious about what we infer from the responses received.

43. Nevertheless, among the 1975 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.

44. 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.

45. 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.

Effectiveness of CPD report

46. The study commissioned by the GMC and Academy of Medical Royal Colleges (AoMRC) into the effectiveness of CPD has provided important insights into our future regulatory role and some helpful notes of caution.

47. 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 rewarding. There is no single, correct way of doing CPD 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

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6 http://www.gmc-uk.org/CPD_Survey_Summary_Mar_Aug_11.pdf
8 Ibid p 20
demands for increasing accountability for CPD activity and the quantification of learning\textsuperscript{10}.

Lessons from other regulators

48. We spoke to a range of regulators and other bodies in the UK about their approaches to CPD\textsuperscript{11}. We also reviewed the systems operated by medical regulators worldwide. A detailed report on international models is on the GMC’s website.

49. 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.

Consulting on our role in CPD

50. We are now consulting on the draft CPD guidance, our plans to implement the recommendations and our possible role in facilitating more effective CPD for doctors.

51. As part of our consultation, we are asking for feedback from particular groups of doctors on the impact of our work on CPD. We also plan to give opportunities to doctors with protected characteristics to raise any further concerns.

52. We will explore specifically whether our work on CPD imposes unnecessary barriers on their development and whether there are further areas where we may be able to reduce inequalities. Indeed we have explicitly asked in our consultation questions whether our work will have any negative impact on particular groups of doctors and how may we address them if they arise.

53. We will also seek views from a wide range of interest groups including diversity groups, patients and members of the public, employers, academic institutions and the profession in order to ensure our recommendations for CPD meet the needs of patients, the public and the service as a whole.

54. We will identify good or notable practice for CPD to help illustrate ways CPD may improve medical practice. We will seek examples of CPD specifically targeted at

\textsuperscript{10} Ibid p 41
\textsuperscript{11} 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.
these categories of doctors or protected characteristics. These examples will be identified through consultation and research.

55. We will also explore ways in which we can identify and publicise issues which appear likely to 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.

56. We have identified as a priority a need to engage with:

- Doctors as a general group
- Specific groups of doctors that will be affected by our policies such as SAS, locums, part-time workers, doctors in career transitions, trust-grade doctors, trainees etc.
- Medical Colleges and Faculties
- Medical schools and Students
- Employers
- Diverse groups of patients/public

57. We aim to work with a number of teams within the GMC to engage with these doctors in a joined-up way (for example, to piggy back on their events) and to ensure our guidance reflects the overall approach of the GMC including Standards, Fitness to Practise, Revalidation and Education.

*Stakeholder groups*

58. The AoMRC Directors of CPD (DCPD) is developing CPD mechanisms/frameworks for medical colleges in order to promote a more consistent and joined up approach to CPD. The chair is a member of our review group.

59. Individual medical colleges and speciality societies – we will meet with these organisations as necessary to bring them along with any policy development.

60. British Medical Association (BMA) and in particular the Staff and Associate Speciality doctors Committee (SASC) will have an interest in this project. We will have regular meetings with the chair of the SASC and we will consult with the BMA as a whole as part of the consultation.

61. Employers will be an essential element of any of our work on CPD. We have a member of the review group from NHS Employers England and will endeavour to consult with appropriate employer groups in the other countries.

62. Deaneries are essentially the funding/training organisations for doctors and will need to be part of any review of CPD. We have members from CoPMED and CoGPED on the review group.
63. We will engage with patients/public either through the consultation or Reference Community as appropriate. If we identify any specific areas that would impact on any particular groups, we will meet with them to discuss it in more detail.

64. We need to engage directly with doctors in order to seek feedback and comment from those people who will be directly affected by our work. We will do this through web surveys, communication through doctors’ groups like the BMA, consultation, research and other communication activities.

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Planned engagement</th>
<th>Summary of feedback</th>
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<tbody>
<tr>
<td>Race</td>
<td>We plan to engage with SAS doctors, the majority of whom are trained outside the UK and / or are part-time workers (mostly women). We will meet with the BMA SASC, who have offered to send out / inform their members of any developments / consultations. The communications plan will include engagement with our BME Doctor Forum contacts.</td>
<td>We have regular meetings with the chair of the BMA SAS Committee who is supportive of our work on CPD. We will be speaking during the consultation at two BMA SAS events.</td>
</tr>
<tr>
<td>Gender</td>
<td>We plan to engage, in particular, with the Medical Women’s Federation.</td>
<td>The MWF spoke at our CPD seminar in May and has been kept up to date with the development of our work on CPD.</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>We will ensure that our communications plan reflects engagement with trans groups of patients and the public.</td>
<td></td>
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<tr>
<td>Disability</td>
<td>We know that people with disabilities have particular concerns about their access to healthcare and treatment by doctors. We also know that doctors sometimes struggle to deal with patients with disabilities appropriately and CPD may be a mechanism to support improvements in care for patients. As such, we need to engage with patient groups to identify what may be needed (as highlighted in the Equality</td>
<td></td>
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consultation). Equally, we know that doctors with disabilities have particular needs and experiences with CPD such as poor access, time out of practice etc which we may be able to clarify and support through our guidance. We need to engage with doctors groups on these issues.

| **Age** | Although it is not necessarily an age issue but rather a training and career progression issue, we will engage with students and trainees to make sure we are fostering a culture of lifelong learning. We will also think about how doctors at different stages of their careers may be affected by CPD guidance and where they may need further support. A lot of this work will flow not only from the consultation but also the ongoing work on the review of the register and scope of practice. |
| **Sexual Orientation** | Given some of the issues raised in the equality consultation, it may be helpful to engage with groups representing gay, lesbian and bisexual patients as well as doctors such as GLADD through our consultation. |
| **Religion and Belief** | We will ensure that our communications plan includes engagement with different religious groups representing the interests of patients and the public. |
Addressing barriers for protected characteristics

Race

65. There is little information about the contribution or limitations of CPD (except for the 2009 report for the GMC by Jill Schostak and colleagues) for example in relation to equality and diversity issues. But career limitations facing specialty doctors are accepted and IMGs have been shown to face cultural challenges (Warwick report).

66. Although the GMC should not become involved directly with employment contracts, funding for training, time allotted for training etc, doctors could use our principles and guidance as a lever to make CPD one of the cornerstones of their practice. Our involvement in CPD may also encourage employers, local authorities, government to protect resources for training and development. We know, for example, from our early engagement work through the CPD seminar, the GMC SAS roundtable and the CPD survey that SAS doctors welcome guidance from the GMC that makes clear their need for access to CPD resources.

67. SAS doctors or trust grade doctors (groups where IMGs and women are traditionally over-represented) may need support in accessing resources to undertake CPD and may want opportunities to develop their career further either in their specialty or indeed into management. Similarly locums often experience situations where employers do not recognise their CPD requirements and do not give them access to development opportunities (like appraisals and training) 12.

Action:

68. Our guidance emphasises the need for all doctors to have access and support for their CPD.

Gender

69. A more flexible, quality based approach will support some doctors to undertake effective CPD within their different work patterns such as part-time workers (mostly women), doctors with long-term health conditions and disabled doctors.

70. Requiring doctors to stay up to date and meet specific CPD standards will likely result in doctors working part-time having to undertake CPD outside of work hours in order to meet our requirements.

12 Di Jelley, Revalidation processes for sessional GPs: A feasibility study to pilot current proposals, Royal College of GPs, 2009.
Action:

71. In general, cost and work-life balance may be significant barriers to CPD (2009 effectiveness of CPD research report).

72. However, the review 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.

73. 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.

74. 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.

Pregnancy/Maternity

75. Doctors on maternity leave may have different CPD issues. For example, should we expect doctors on maternity leave to undertake CPD while on leave or are there ways to encourage an approach that integrates them back into the system after their leave. There may be particular legal considerations about maternity leave that impacts on CPD.

76. We anticipate a flexible approach to CPD along with a strong message that employers should support all doctors with their CPD will help foster a work environment where women will be able to either carry out their CPD during their leave

Gender Reassignment

77. Our facilitative role in CPD may provide an opportunity for us to raise awareness about a range of issues or areas of knowledge that may be relevant to doctors.

Disability

78. There is extensive information about the lack of and poor quality of healthcare for certain groups including people with learning disabilities and people from
disadvantaged socio-economic groups. CPD could help to equip doctors with key knowledge, skills and behaviours to meet the needs of disadvantaged groups.

79. Flexible provision of CPD could particularly benefit doctors with disabilities and allow them to keep up to date even when out of practice.

Action:

80. Doctors on long term sick leave may find it difficult to access CPD or to demonstrate benefit. Concerns have been raise both in research by the Women’s Medical Federation\textsuperscript{13} and in our informal CPD survey\textsuperscript{14} that access and support for CPD is often difficult for doctors working part-time or not at all for a period.

81. GMC should stress the importance of accessibility of CPD for all doctors and emphasis the role of employers in supporting all doctors in their CPD.

82. We will make sure the CPD guidance is clear about our expectations for CPD for all doctors and set out what we would like employers to do to better support doctors regardless of their work pattern. And we will also consider how to embed the guidance into local processes to make sure it is effective and can be used as a means of support for both employers and doctors.

Age

83. There are different CPD needs depending on the role and point in career of the doctor. It is particularly important that access to CPD is not limited, in particular, to older doctors or those reaching retirement.

Action:

84. The GMC has an opportunity to encourage specific groups of doctors to think about particular areas for CPD e.g. genomics, which doctors who are no longer in training will not have learned about during their training.

Sexual Orientation

85. CPD could raise awareness and help to tackle a lack of understanding, knowledge and skills in managing gay and lesbian patients. If we develop a way to share information about areas where CPD may be of value, we can look at groups of patients or areas of medical practice where there is evidence that further learning or development would help patient care.

\textsuperscript{13} Making Part time Work, Medical Women’s Federation, 2008.
\textsuperscript{14} http://www.gmc-uk.org/CPD_Survey_Summary_Mar_Aug_11.pdf_44814620.pdf
Religion and Belief

86. Our role in CPD could raise awareness of doctors’ ethical and professional duties set out in GMP.

Reviewing and monitoring

87. This Equality Analysis will be treated as a living document and will be updated as we reach specific milestones in our processes. So we will aim to update the EA with the outcomes of the consultation and highlight particularly relevant feedback from people with protected characteristics.

88. This EA sits beneath the Education Equality Plan which is updated on a regular basis and forms part our operational report to the Education and Training Board.

89. We have identified the diversity groups for both doctors and patient/public that we must encourage to participate in the consultation on CPD. We will actively seek their feedback and will evaluate the outcome of this EA against the success of engaging with these groups. At the very least, we would like to hear from doctors working in SAS and locum roles as well as doctors working part-time about the impact of our proposals for CPD. We would also like to explore some of the barriers accessing CPD faced by doctors with disabilities or long term health conditions.

Action Planning

<table>
<thead>
<tr>
<th>Reference to paragraph in main text</th>
<th>Issue</th>
<th>Action</th>
<th>Time frame</th>
<th>Manager/AD</th>
<th>Relevant protected characteristic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Para 14</td>
<td>The GMC has an opportunity to encourage specific groups of doctors to think about particular areas for CPD e.g. genomics, which doctors who are no longer in training will not have learned about this</td>
<td>We are consulting on this role and if there is support for it, we will look to develop the proposal further in 2012.</td>
<td>Scope out proposal in Spring 2012.</td>
<td>Paula Robblee, Richard Marchant</td>
<td>May have implications for all protected characteristics depending on the nature of our proposals.</td>
</tr>
<tr>
<td>Para 24</td>
<td>Research and monitoring of the effectiveness of CPD and the GMC’s role in CPD.</td>
<td>We have commissioned research on the impact of CPD on performance</td>
<td>The research is due to complete in August 2012</td>
<td>Paula Robblee Thomas Jones Richard Marchant</td>
<td>It is looking at barriers and good practice across different sites and professional roles. It may also look at the impact on patients. Again, depending on how the research develops, it may identify issues for the protected characteristic groups.</td>
</tr>
<tr>
<td>Para 25 to 35</td>
<td>The principle and guidance will reflect equality and diversity opportunities and we will try to influence others to consider these issues as part of their CPD planning, development, provision etc.</td>
<td>The draft guidance is explicit that all doctors must undertake relevant CPD for their medical practice to ensure they are up to date and fit to practise.</td>
<td>We are consulting now and anticipate publishing a final version of the guidance in Spring 2012</td>
<td>Paula Robblee Richard Marchant</td>
<td>We will consider implications for particular groups of doctors such as SAS, locum and part time workers.</td>
</tr>
<tr>
<td>Para 14</td>
<td>Ways of encouraging the use of the CPD guidance at local levels</td>
<td>We are thinking of ways of making the guidance and subsequent work on CPD more</td>
<td>We are consulting now and anticipate putting together a plan for embedding the</td>
<td>Paula Robblee Richard Marchant</td>
<td>We may find out about particular issues and barriers for groups of doctors such as SAS etc which we may then think about how better to support them with</td>
</tr>
</tbody>
</table>
effective at local levels such as working with Responsible Officers and Appraisers guidance in Spring 2012.

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<tr>
<th>Sign off</th>
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<tbody>
<tr>
<td>EA lead: Paula Robblee</td>
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<tr>
<td>Directorate: Education</td>
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<tr>
<td>Responsible Assistant Director: Richard Marchant</td>
</tr>
<tr>
<td>E&amp;D team: Aishnine Benjamin</td>
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</tbody>
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