To consider

Evaluation of our continuing professional development work stream

Issue

1. A look at our commitments and developments on continuing professional development. This paper sets out some of the products we are developing to meet external expectations and proposes future work.

Recommendations

2. The Strategy and Policy Board is asked to agree:

   a. That the GMC’s continuing professional development work continues to meet our external commitments, addresses future risks and opportunities and supports other business areas of the organisation.

   b. To develop a formal project for continuing professional development that would include further guidance, practical support for appraisers and employers, as well as signpost key areas for doctors’ continuing professional development.
Evaluation of our continuing professional development work stream

Issue

Guidance

3 We published Guidance for doctors about their continuing professional development (CPD) in 2012. Its purpose was to set out what we expect doctors to do to meet our CPD requirements for revalidation. We emphasise that doctors must manage their CPD through job planning and appraisal processes.

4 A core theme running through the Guidance is the need for doctors to reflect on their practice and performance. We ask them to identify through reflection what learning and development they should undertake to better care for their patients and improve the quality of the service. We also require doctors to reflect on whether their learning and development experiences were useful and will improve their practice and performance.

5 We ask doctors to focus on the quality and outcomes of their learning and development rather than the number of hours or credits obtained. Our position is based on evidence that structured and managed CPD related to doctors’ jobs – now or in the future – improves their practice*. It would be disproportionate for us to refuse to revalidate doctors who can show they are up-to-date because of the quality and breadth of their learning and development activities, but have failed to meet a specific number of CPD credits.

Supporting doctors throughout their careers

6 Alongside the guidance, Council agreed in 2012 that we should develop mechanisms to support doctors in identifying areas where learning and development might be useful. This facilitative role would allow us to highlight professional, regulatory and legislative developments that could direct or influence doctors’ CPD.

7 We are clear that this function must not duplicate what the medical Royal Colleges and others do in terms of specialty specific CPD. Rather, we will develop content to support reflective practice and appraisal and to improve professional development in generic professional areas. Signposting to other resources and partnering with relevant organisations will be crucial in order to generate good quality and useful information.

As part of this initiative, we are currently developing a CPD mobile device application (app) for all doctors to help them plan, carry out and evaluate their CPD. It is based on our CPD guidance and emphasises the importance of relevant and reflective CPD as part of appraisal processes. This product will give us a greater access to the medical profession to promote and provide support on professional, legal and ethical issues. Once the app is launched, we will provide regular updates, case studies and signposting to appropriate training and education opportunities.

New developments in our CPD work area

Commitments that we have made about CPD

We made a commitment this year to the Professional Standards Authority (PSA) to provide doctors with advice to help them follow good practice as part of their CPD cycle, including support on how to reflect effectively on their practice. We would like demonstrate progress in these areas in 2015.

In order to support doctors care for patients at the end of their lives, we agreed, as part of the Independent Review of the Liverpool Care Pathway – One chance to get it right – ‘to publish advice to help doctors access guidance and other learning opportunities on end of life care, that support doctors’ continuing professional development’. We have made similar commitments to questions arising from the Medical Innovation Bill about our research guidance for doctors.

We hope to expand this useful approach to support other guidance areas. This fits nicely with recommendations in the review of our standards function. It confirmed that we need to develop mechanisms to help doctors access CPD materials relevant to all our professional and ethical guidance. Work on end of life care on CPD, discussed below, will provide a potential model that could be rolled out for other core areas.

Since revalidation was introduced in 2012, all doctors must have annual appraisals and bring evidence, among other things, of effective CPD to these conversations. As more doctors engage with appraisal and revalidation, demand for support about CPD will inevitably increase. For example, both Colleges and individual doctors have contacted us for advice on reflection and reflective practice in the last two months.*

External drivers that will impact on CPD

There is increasing expectation that we, as the regulator of doctors, have a duty to provide standards, guidance and support on CPD. We need to take note of, and plan

* It isn’t a large number (6). But we haven’t had these types of requests in the past. It suggests a growing expectation that we provide more support in this area.
for, potential changes to our role in CPD as a result of legislative and political requirements. This is described in more details in the supporting information section of this paper (paragraphs 20-22).

Cross-cutting work in the GMC

14 Responsibility for CPD policy sits within the Education and Standards Directorate, but it touches on all business areas of the GMC. More information about these activities is in the supporting information section.

Next steps for our CPD work

Advice and support for doctors about their reflective practice

15 We are completing work that has identified key issues and areas about reflection and CPD. This work will help us better target advice to doctors about their reflective practice. As part of this phase, we have:

a Undertaken desk research to look at the evidence and data that demonstrate the impact and effectiveness of reflection in professional practice. We have also looked at the College and Faculty guidance and processes about reflection as part of the CPD requirements.

b Asked our Regional Liaison Service to seek feedback from groups of doctors about their concerns about reflection and reflective practice. Early trends suggest that some doctors resist the need for reflection as part of appraisal and CPD because it is seen as another box-ticking exercise. They think the processes are divorced from their day to day practice.

c Produced a reflective records template for our Standards work such as the Better Care for Older People webpages. We have asked a group of doctors to use the webpages and the reflective record template to inform themselves about caring for older people. They will feedback about their initial experience and the impact of the learning after three months.

16 Using the information from the scoping phase, we will develop joint advice and case studies with the Academy of Medical Royal Colleges about reflective practice. It will also be used to update the CPD app.

Piloting our facilitative role in end of life care

17 We intend to test ways of embedding training on end of life care into local systems through education and appraisal processes. This will allow us to meet our commitments to the Liverpool Care Pathway Inquiry. As part of this, we will invite a
small group of Directors of Medical Education, from the four UK countries, to help us with this work and measure the impact of this activity.

**Focused themes for learning and development**

18 We are collaborating with colleagues across the organisation to develop a joined-up approach to identifying ‘hot topics’ or focused themes. These will draw from information and data we collect as part of our work on professionalism, including the Standards ethical review, government priorities and trends in professional development. As part of this strategy, we will raise awareness of critical issues and how they relate to our guidance, identify key learning areas and outcomes through good practice or case studies, signpost to relevant resources, and, where possible, require the learning to be built into doctors’ professional development.
Supporting information

How this issue relates to the corporate strategy and business plan

19 Strategic aim 2: to help raise standards in medical education and practice.

External drivers of change

20 The Greenaway review on the shape of postgraduate training – *Securing the future of excellent patient care* recommended that CPD should be more clearly aligned with patient and service needs. Doctors must demonstrate they are up to date in each of the domains of *Good medical practice*. Greenaway also recommended that doctors should have more structured CPD requirements based on generic professional capabilities such as clinical leadership and communication. We are already developing a generic professional capabilities framework for postgraduate training, which could be adapted to inform doctors’ CPD.

21 The European Commission is becoming increasingly interested in using evidence of CPD to give assurance that healthcare professionals are meeting common practice standards. At a recent EU Commission CPD workshop, the project team suggested the *Directive on the Recognition of Professional Qualifications* should include mandatory CPD requirements for all healthcare professionals. Although DG Internal Market indicated it was unlikely to go down this prescriptive route, other levers may be considered. In order to lead in this area, we must demonstrate that our approach is robust, effective and evidence-based.

22 The Law Commissions Bill will likely require regulators to set standards for CPD. We might have to be more explicit about what learning and development will be expected from doctors throughout their careers, in order to exercise our education functions. Our guidance on CPD, strengthened by supplementary advice could easily be modified to meet these requirements.

Cross-cutting work in the GMC

23 It is one of the sources of information in revalidation used to determine if a doctor is up-to-date and fit to practise. We produce a wealth of learning materials for doctors to help them reflect on their understanding of their professional duties and responsibilities. We also have programmes such as *Welcome to UK Practice* and the Learning Disabilities website that provide structured learning and evaluation for doctors.

24 Feedback indicates there is an appetite from key interest groups to grow these types of activities. Several organisations with expertise in end of life care are keen to develop, in partnership with us, training materials and packages to promote good practice.
Over the next few years, we will build a better understanding of how CPD works as part of the appraisal process. We know from research that doctors are more likely to improve their practice when their CPD is explicitly linked to their job through the planning and appraisal processes\(^1\), but few studies have looked at the quality of CPD as part of appraisal or its impact on patients or the service. The evaluation of revalidation will span three years, covering the first cycle of revalidation and will look at the key areas of revalidation, including the quality of supporting information doctors bring to their appraisals. The research will specifically look at the impact of reflection on practice and will help us consider how we can better use our role in CPD to raising standards.

The Regional Liaison Service (RLS) speaks with employers and doctors about revalidation as one of their priority areas. As part of these sessions, our Regional Liaison Advisers provide advice and support for doctors about CPD and in particular, reflection. They have identified a number of misunderstandings by doctors and appraisers about credits and hours as well as the relationship between CPD, job planning, appraisal and revalidation. To address these concerns, we wish to provide further information and learning materials for doctors and appraisers about reflective practice, how to use job planning and appraisal as learning and development tools and a clearer steer to appraisers and Responsible Officers about how to make decisions on doctors’ CPD.

In our review of CPD in 2011, we identified a number of challenges in accessing CPD faced by groups of doctors with specific protected characteristics such as disability, race and gender. Many doctors, particular in Staff, Associate Specialist and Specialty (SAS) and locum positions, struggle to get effective learning and development opportunities\(^2\). This has lessened to some extent with the requirement for annual appraisals, but these groups still need support in using CPD to help them identify opportunities in clinical leadership\(^3\). Targeted guidance, support and advice along with facilitating learning and development opportunities will help us meet our public duty under the *Equality Act*.

If you have any questions about this paper please contact: Paula Robblee, Policy Manager, Education and Standards, [probblee@gmc-uk.org](mailto:probblee@gmc-uk.org), 020 7189 5207.

---

\(^1\) Professor Nigel Mathers, Dr Caroline Mitchell and Amanda Hunn. (2012). Assessing the impact of continuing professional development (CPD) on doctors’ performance and patient/service outcomes. Commissioned by the GMC.

\(^2\) Gillian Phazey, Steven Agius, Jacky Hayden (April 2012). SAS doctors’ perceptions of their role in the NHS. BMJ.

\(^3\) Umesh Dashora (January 2014). Why don’t staff, associate specialist, and specialty doctors engage more fully with the CPD opportunities offered to them? British Medical Journal.