Report of the Consultation on the GMC’s role in Continuing Professional Development (CPD)

Background

1. Good Medical Practice requires doctors to keep their knowledge and skills up to date throughout their working lives and regularly take part in educational activities that maintain and further develop their competence and performance.

2. In our 2004 guidance, Continuing Professional Development, we described ways doctors might identify their learning needs and keep up to date. Since then, much has changed.

3. The merger of the PMETB with the GMC in 2009 made the GMC responsible for regulating all stages of medical education and training. This includes ensuring proper standards in the practice of medicine once a doctor’s formal training is complete.

4. The introduction of revalidation at the end of 2012 will place a greater emphasis on doctors’ CPD activity as a means of showing that they remain up to date and fit to practise throughout their careers. At the same time, there is greater pressure on the resources available to support doctors’ CPD activities within the workplace.

5. In the light of these and other changes Lord Patel’s March 2010 report Recommendations and Options for the Future Regulation of Education and Training 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.’

Our review of CPD

6. Between November 2010 and July 2011 we carried out a review of our role in regulating doctors’ CPD. The review produced a report for the GMC’s Council containing nine recommendations.
Recommendations on the GMC’s role in CPD

Recommendation 1: The GMC must provide a framework of principles and guidance to support doctors in planning, undertaking and evaluating their CPD activities.

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.

Recommendation 3: The GMC should endorse the principles and guidance proposed by the CPD review.

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.

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

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.

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.

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.

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.

Consultation methodology

7. The conclusions of the review were in part the result of extensive engagement with our key stakeholders before we reached the stage of formal consultation on our proposals. The review report describes how we did this.

8. From 17 October 2011 to 10 February 2012 we conducted a public consultation on the review conclusions. The consultation included 11 questions (see Annex A). This report sets out the results.

9. Details of the consultation were promoted on our website. Consultation responses could be provided online using our e-consultation tool, by email or in writing.
10. In addition, information about the consultation was sent to over 200 organisations. These included doctors’ groups, patient and public groups, organisations employing or contracting with doctors, and the medical Royal Colleges and Faculties. Information was also sent to CPD Leads at the Strategic Health Authorities in England, the Health Boards in Scotland and Wales and the Health and Social Care Trusts in Northern Ireland.

11. We included information in two GMC e-newsletters, which are sent to more than 100,000 contacts including doctors, patient groups and employers of doctors. We also included items in the GMC Education e-newsletter, which is circulated to over 900 contacts interested in medical education and training.

12. We recognised in our equality analysis that our work may have implications for Staff, Specialty and Associate Specialist (SAS) doctors, sessional GPs and locums. We therefore targeted the Associate Deans of SAS doctors and SAS tutors at the postgraduate deaneries so that they could promote the consultation. The BMA SAS Doctors Committee also sent information to its members.

13. The British Medical Association (BMA), NHS Employers, British Association of Physicians of Indian Origin (BAPIO) and the medical Royal Colleges circulated information to their members and many of them put links to the consultation on their websites.

14. We used various GMC events to promote the consultation. This included distributing over 500 postcards containing consultation information and around 350 paper copies of the consultation documents. During the consultation period 1,254 people visited the CPD consultation webpage.

15. We discussed the consultation at 12 events. In particular, we met with groups representing employers, SAS doctors, sessional GPs and locums in England and Wales. We also spoke with three patient / lay groups. We have incorporated the comments from these events into the overall analysis of the consultation provided in this report.

16. We received a small number of consultation responses by email and letter. Where possible, we integrated these into our responses database against the appropriate consultation question. Where email or letter responses could not be matched to particular consultation questions they have been considered as general comments and incorporated into the overall analysis.

**Consultation analysis: an overview of responses**

17. We received 158 people responses to the consultation. Of these, 113 were from individuals and 45 were from organisations.

18. Respondents were not required to answer every question. We evaluated each question based on the number of responses it received rather than the overall response rate.
19. For each question, respondents were invited to answer ‘Yes’, ‘No’ or ‘Don’t Know’. They also had the opportunity to provide further comments. In many cases, comments were not provided. Where we received comments, we have used them to qualify or explain the overall response to the questions.

20. Many respondents only answered the first question in the consultation but provided comments applicable to other consultation questions. Where this is the case, we have considered the comments within the most relevant question.

**Individual respondents**

21. The largest group of individual respondents was doctors (60%). But we allowed respondents to feedback as guests on the online version of the consultation, resulting in a significant minority falling into an ‘unknown’ category (34%).

22. 58 doctors indicated the role in which they worked. In addition to their primary roles (for example, as consultants or GPs) 22% of doctors also identified themselves as medical educators. The figure below shows a breakdown of the doctors who responded.

![Categories of doctors (58 responses)](image)

23. 54 doctors responded about their pattern of work with most in full time employment. 28% of doctors said they worked part time. Women made up the majority of part-time workers (57%).

**Organisational respondents**

24. Of the 45 responses from organisations, postgraduate medical institutions were by far the largest category (38%). This included feedback from the Academy of Medical Royal Colleges (AoMRC) and from 14 medical Royal Colleges and Faculties. We also had responses from the Committee of General Practice Education Directors (COGPED) and from one deanery.
25. 22% of responses came from employers or organisations contracting doctors’ services. The majority of these were from NHS / Health and Social Care (HSC) organisations. They included NHS Employers and six Primary Care Trusts (PCTs). One independent healthcare provider/employer responded.

26. Bodies representing doctors accounted for 20% of organisational responses. They included the BMA, the Independent Doctors Federation (IDF), the Medical Womens’ Federation (MWF), BMJ Learning and three medical defence unions.

27. We received four responses from organisations representing patients and the public, including from the Patients’ Association. Two regulators responded and three organisations with a focus on higher education.

**Summary of the consultation results**

- The overwhelming majority of respondents agreed we should provide a high level framework of principles and guidance on CPD.
- Most respondents agreed that our draft guidance balanced the needs of individual doctors with those of their teams.
- Some respondents suggested the draft guidance needed more emphasis on the role of patients within CPD planning.
- Many respondents suggested areas where they would welcome more specificity in the guidance, including mandatory CPD requirements such as credits/hours.
- Many respondents wanted the guidance to be more prescriptive about the responsibilities of employers for ensuring access to CPD. This was often linked to the view that greater prescription would help to ensure funding for CPD.
- A majority of respondents agreed with our plans to embed CPD into appraisal and job planning processes.
- Most respondents liked our idea of sharing information with doctors in order to help them reflect on their learning needs.
- Respondents identified a wide range of barriers to doctors’ planning, carrying out and evaluating CPD. These included restrictions on time, funding and other resources.
- Respondents also identified groups of doctors for whom CPD may be a challenge. These included SAS doctors, locums, doctors working part time, those on career breaks, doctors working in geographically isolated areas, doctors in non-clinical practice and doctors with portfolio careers.
Consultation analysis of individual questions

What people said about our proposed framework of principles for CPD

28. We proposed that the GMC’s role in CPD should be to provide a high level framework of principles and guidance which set out how we expect doctors to plan, carry out and evaluate their CPD. The framework should not prescribe particular CPD activities that doctors must undertake or the amount of CPD required. These more detailed and individual requirements should instead be identified, discussed and monitored locally through doctors’ job planning and appraisal.

Question 1 – Overall Framework and guidance

29. We asked ‘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?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>100</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Organisations</td>
<td>40</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>140 (90%)</td>
<td>10 (6%)</td>
<td>6 (4%)</td>
</tr>
</tbody>
</table>

30. Of the 156 responses received, 93% of organisations and 88% of individuals agreed that the GMC should provide a high level framework and guidance for CPD. There was consensus from all the bodies representing doctors, organisations employing or contracting doctors and other regulators. Similarly, the majority of doctors, ‘unknown’ respondents, medical managers and members of the public agreed with our approach.

31. Respondents who didn’t agree with our proposal or didn’t know wanted the GMC to be more prescriptive. A small number of respondents did not want the GMC involved in CPD at all. This was either because they saw it as a matter for the profession rather than the regulator or because the GMC did not have sufficient understanding of subspecialty needs.

32. The support for a high level framework of principles and guidance was reflected in respondents’ comments. The BMA said:

‘A framework is more appropriate than prescriptive guidance, as this enables doctors to address their own personalised learning needs in a formative and flexible way. This flexibility in particular allows for the capturing of both formal and informal CPD activity, moving doctors away from ‘tick-box’ CPD activity and the minimum required for revalidation.’ (British Medical Association)
33. Other organisations, such as the Medical Protection Society, BUPA and the RCGP voiced similar support to this approach.

34. COGPED saw a GMC framework as likely to help organisations in their efforts to promote CPD locally.

‘This would assist deaneries in developing a CPD strategy and to advise both commissioning and providing organisations moving forward. In the current round of efficiency savings, CPD services, advisory and directly delivered by deaneries, have been an area of disinvestment.’ (CoGPED).

35. However, many respondents took the opportunity to highlight the role of the medical Royal Colleges in CPD. For some, such as BUPA, this was about recognising that while the GMC should set ‘a framework of principles and guidance’, ‘specific CPD guidance should come from Royal Colleges and Faculties, or specialist societies’. Most colleges wanted GMC guidance to provide more explicit endorsement of the CPD principles developed by the Academy of Medical Royal Colleges and of College CPD credit systems.

36. About a fifth of respondents wanted the GMC either to set a minimum standard for CPD or endorse College credit based requirements which prescribe at least 50 credits (hours) a year. Respondents from postgraduate medical institutions, individual doctors and patients’ groups all suggested that minimum requirements prescribed by the GMC would help doctors obtain resources for CPD (including time) from employers. One respondent felt that where there were no intermediate management structures between the individual doctor and the regulator, counting hours might be relevant.

37. They also argued that minimum CPD requirements would provide clarity for appraisal and revalidation. For example, the Patients’ Association wanted mandatory requirements set against the Good Medical Practice Framework for appraisal and revalidation. On doctor responded:

‘Everyone knows what the minimum expected standard is and it makes it easier for appraisers and medical managers to encourage doctors.’ (Doctor)

38. Despite the prevailing view that the GMC’s role should be to set high level guidance rather than detailed prescription, many commentators also wanted particular subjects covered within the more generic framework. These included equality awareness, communication and leadership skills, engagement with peers and mandatory requirements in areas such as child protection, CPR and basic life saving. Two responses also highlighted the need for learning in areas with which doctors may be unfamiliar. For example:

‘I do believe that there may be a case for greater prescription in the Council’s approach to CPD in certain circumstances and the advent of genomic medicine is a good example of this… Most doctors know little about this and many that do not appreciate fully its relevance to their own work …Unless there is a combination of regulatory prescription as well as good guidance I fear CPD will not rise to this unusual challenge. Exactly how this can be done
is not clear. It will require close collaboration with Royal Colleges and others, but only the regulator can provide the “steel” required.’ (Doctor)

‘…the GMC might need to highlight the specifics of certain issues such as trans[gender] awareness and equality training as education around transexuality and pathways for gender reassignment are often “below the radar” and won’t necessarily be picked up by GPs when deciding their CPD.’ (Trans Resource and Empowerment Centre)

Our response

39. We agree that it is not appropriate for the GMC to provide guidance on, or deliver, CPD relating to specialty matters. That is better done by the Colleges and other specialist bodies. Our generic guidance has been informed by, and makes reference to, the Academy CPD principles. It also highlights the important role of the Colleges and others in relation to CPD in their specialty areas.

40. Our draft guidance makes clear that doctors are expected to take account of the Good Medical Practice Framework for appraisal and revalidation when considering their CPD needs. However, a national CPD prescription for all doctors would run the serious risk of diverting resources into activities which will be irrelevant to the needs of many doctors, the service within which they work and, above all, their patients. We remain of the view that doctors’ individual CPD needs should be determined locally against national principles and guidance set by the regulator. This is also consistent with the approach we have taken in relation to revalidation.

41. We can, however, add value by using our position to highlight areas of learning and development (such as in genomic medicine or leadership or transgender awareness) so that doctors and their appraisers can reflect on the implications for their own CPD needs. We discuss this further under question 9 of this report.

42. A number of respondents have urged us to specify the number of credits or hours’ CPD doctors must undertake, linking this to the requirements of College CPD programmes. In our guidance we recognise that many doctors and employers find this a helpful means of demonstrating a level of participation in CPD and we should not discourage this. However, we are not persuaded that it would add value for the regulator to prescribe minimum time inputs for CPD. It may encourage minimum compliance at the expense of genuine reflection on CPD needs and outcomes within appraisal. It could also encourage some to limit participation in and resources for CPD to reflect the minimum prescribed rather than to address an individual’s real learning and development needs.

43. Imposing a regulatory requirement of this kind would also imply a regulatory penalty for those who do not meet the requirement. Yet it is highly unlikely that we would wish to initiate fitness to practise proceedings against a doctor who has undertaken 49 rather than the prescribed 50 hours’ CPD but who is shown through revalidation to be performing to appropriate professional standards. The more appropriate focus for the regulator is on outcomes.
What people said about our draft CPD guidance

44. We asked six questions about our draft guidance. Many of the responses suggested specific changes to the guidance. Where appropriate these have been incorporated into the revised guidance at Annex C.

Question 2 – Emphasis on patients

45. We asked ‘Does the guidance place appropriate emphasis on doctors’ CPD activities being informed by the needs of patients and the public?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>82</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Organisations</td>
<td>29</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>111 (84%)</td>
<td>17 (13%)</td>
<td>4 (3%)</td>
</tr>
</tbody>
</table>

46. Most respondents agreed that the guidance placed the appropriate emphasis on the needs of patients.

47. However, bodies representing patients, organisations focused on higher education and a small number of postgraduate medical institutions (including the AoMRC) raised concerns with the guidance. Participants at our consultation events also suggested that the patient voice had been lost in the guidance.

48. Over a third of respondents said the needs of patients and carers should be more prominent. Some wanted more explicit use of patient feedback as a means of identifying relevant CPD requirements. BMJ Learning argued that greater emphasis on improving patient outcomes would help shift attitudes away from counting CPD credits.

‘The GMC does place emphasis on the need for CPD to be based on the needs of patients and the public but could perhaps place this general principle more prominently in the final version of the GMC’s guidance...Providers of CPD are continually asked by doctors “will I get points for attending your course?”; it would be much better if the GMC could help generate a culture where doctors would ask “will this course help my practice and my patients?”’

(BMJ Learning)

49. The AoMRC found that the guidance did not give sufficient emphasis to CPD activity needing to be informed by the needs of patients:

‘Not sufficiently. The relevance of CPD to the quality of care provided to patients and/or the public is mentioned in several paragraphs of the guidance (6; 11; 24; 25; 55). These statements indicate that CPD is important to improve the quality of care provided. However, there is less emphasis on CPD
activity being informed by the needs of patients, carers and the public – something which we would expect. (AoMRC)

50. A small number of comments, particularly from doctors, suggested the guidance over-emphasised the relevance of patients in CPD and should instead focus on doctors’ needs.

Our response

51. Although most respondents agreed that we have given appropriate emphasis to the needs of patients, we have made a number of amendments to the guidance to provide greater clarity. Changes include giving greater emphasis to the need for CPD activities to benefit patients and support the service. We have also referred explicitly to the use of information such as patient feedback when reflecting on CPD needs.

Question 3 – Balance of team and individuals

52. We asked ‘Does the guidance appropriately balance the CPD needs of the individual doctor and the needs of the team?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>67</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Organisations</td>
<td>28</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>95 (74%)</strong></td>
<td><strong>19 (15%)</strong></td>
<td><strong>14 (11%)</strong></td>
</tr>
</tbody>
</table>

53. Organisations (72%) and individuals (74%) welcomed our approach in roughly equal proportions. Among others, support came from the AoMRC, the Federation of the Royal Colleges of Physicians (FRCP), the Royal College of Surgeons of England (RCS Eng), the Royal College of General Practitioners (RCGP) and CoGPED. Bodies representing doctors, including the BMA, and all the NHS/HSC organisations endorsed this position.

‘Good to see advice that a doctor should share their learning with the team, and also support for team-based CPD activities - again these seem new and welcome.’ (Whittington Health)

‘Some doctors working in the Independent Sector work as sole practitioners and in general this sector is about patient choice, which in many cases will mean choosing an individual or specific doctor rather than a team or group. It is however accepted that certain specialties, working in a multidisciplinary team is essential. Where this is the case we believe the proposals do balance the needs of the doctor and the team.’ (Independent Doctors’ Federation)
54. Some respondents felt that the guidance over-emphasised teams at the expense of individual doctors. Linked to this were concerns that organisations may prioritise team learning when this may not be relevant for the individual doctor.

‘CPD tends to focus on the individual, and therefore there is a tendency to put emphasis on the needs of the individual doctor rather than the wider team. While there is mention of the needs of the team in the proposals, there is perhaps not a satisfactory balance. CPD is based upon a doctor’s Personal Development Planning (PDP). Therefore, the educational needs of a doctor may differ from the whole team.’ (Royal College of Physicians of Edinburgh)

55. Three respondents suggested a CPD framework that emphasised learning within a team may pose particular barriers for locum doctors. One raised a concern about time for protected learning.

Our response

56. Several respondents also asked for clarity about the role of teams in CPD and about the distinction between team learning and planning individual learning informed by team needs. We have separated this within the guidance. We say that doctors should take account of the needs of their teams when planning their CPD but should consider activities taken alongside team members as part of their CPD.

CPD.Question 4 – Role of appraisal

57. We asked ‘Does the guidance place the right emphasis on the role of appraisal and personal development plans in guiding doctors’ individual CPD activities?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>63</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Organisations</td>
<td>35</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>98 (86%)</td>
<td>9 (8%)</td>
<td>7 (6%)</td>
</tr>
</tbody>
</table>

58. There was strong support across both organisations and individuals for our emphasis on the role of appraisal in shaping CPD activities. The BMA, AoMRC, MWF, IDF and a number of NHS/HSC organisations agreed with our proposals.

‘I’m pleased to see reference to doctors being advised to take account of what others (such as appraisers and clinical governance leads) regard as appropriate CPD activity for them. This is helpful in managing doctors in difficulty.’ (Doctor)

‘In both the Draft Final Report and the Guidance Document there is reference to the importance of the appraiser, both in identifying the learning needs of the
individual doctor, and in evaluating the effectiveness of learning and the impact upon practice. It is difficult to emphasise this too strongly….’ (FRCP)

59. However, respondents also called for more detail on the use of reflection in appraisal, the role of managers and appraisers and how appraisal links to personal development plans. Coupled with this came calls for guidance for appraisers and Responsible Officers. Several respondents questioned whether appraisers who were not from the doctor’s own sub-specialty were in a position to make judgements about that doctor’s CPD needs. On the same theme one respondent wrote of the relevance of ‘a CPD peer supervision group’.

60. Respondents also identified barriers to the use of appraisal for planning and evaluating CPD. These included concerns about access to and the quality of appraisal. There was one comment on current regional variations in the application of appraisal. Locum doctors were seen by two respondents as facing particular difficulties.

Our response

61. We have clarified the role of appraisers within the guidance. The questions in the guidance designed to help doctors evaluate their CPD may be used by appraisers to help doctors reflect on their learning needs. Our plans to embed the guidance within local processes and documentation relating to appraisal and revalidation will help to highlight the principles with appraisers and Responsible Officers. Our guidance also makes several references to the value of involving peers and other colleagues in planning and undertaking CPD.

Question 5 – Role of employers

62. We asked ‘Is the guidance sufficiently clear about the responsibilities of employers and contractors in supporting doctors’ CPD activity?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>40</td>
<td>29</td>
<td>5</td>
</tr>
<tr>
<td>Organisations</td>
<td>15</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>55 (48%)</td>
<td>51 (44%)</td>
<td>9 (8%)</td>
</tr>
</tbody>
</table>

63. Just under half of all respondents agreed that the guidance was sufficiently clear about the responsibilities of employers in supporting doctors’ CPD. NHS Employers was among those who felt that the guidance correctly described the balance of individual and organisational responsibilities.

‘The recommendations set out clearly the respective responsibilities of the GMC, doctors and responsible bodies in supporting doctors to plan, carry out and evaluate CPD activity. We agree that it will be important to embed GMC guidance into local processes and appraisal systems so that all doctors are
supported in their CPD activity. Job planning, in which organisational, team and individual objectives are aligned will be an important means of ensuring the CPD activity and, crucially, the outcome of that activity, meets the needs of both individual doctors and the service.’ (NHS Employers)

64. However, many questioned the effectiveness of the guidance in the current economic climate and said it did not provide enough clarity about employers’ and contractors’ responsibilities. These included the AoMRC, BMA, and the Patients’ Association as well as most of the postgraduate medical institutions that responded.

65. Picking up themes from Question 1, respondents argued that mandatory CPD requirements such as credits/hours would support doctors in securing the resources they needed from employers and guard against the erosion of protected study time. Some individuals argued that CPD must be counted as part of their paid time.

‘There is a continued attack on clinicians SPA time. The guidance needs to be specific about nationally agreed recommendations for SPA activity and what constitutes it. It is imperative that there is a clear onus on Trusts to resource appropriately.’ (Tauton and Somerset NHSFT)

‘The draft guidance fails to address the contextual factors which prevent doctors from participating in appropriate forms of CPD. The GMC should make explicit the requirement for employers to adequately fund CPD by making provision for an appropriate number of SPAs in job plans and provide adequate study leave budgets. The neglect of these factors is a major concern for the medical profession at a time of increasing financial pressures in the NHS and the drive by managers towards service performance targets, with CPD being sacrificed as a result.’ (Royal College of Anaesthetists)

66. Others felt that the guidance focused too much on CPD meeting the needs of the service rather than the needs of the individual.

‘As written, there is a risk that CPD will become service-led and prevent the transferability of skills and knowledge of doctors who move areas. The guidance should clearly state that the learning needs of the individual doctor should be supported, acknowledging the risk that offering purely service-led ‘educational’ opportunities is insufficient if CPD is to be an effective developmental mechanism.’ (BMA)

67. Other respondents suggested areas where further clarity or guidance would be welcomed. There was support for more structured person development plans based on specific CPD areas; more details on the responsibilities of organisations contracting or employing doctors within the independent sector; and recognition that employers have a responsibility for the longer term development needs of their doctors including any potential change in roles and practice.

68. A small number of responses suggested particular groups of doctors such as part time employees, SAS doctors and locum doctors are often disadvantaged in accessing CPD. They said that more emphasis should be put on the need for all doctors to have access and support for CPD within the workplace.
Our response

69. For the reasons set out in paragraphs 39-43 we do not agree that it is for the regulator to prescribe the amount of time that must be allocated to doctors’ CPD. Our guidance emphasises the responsibilities of employers and the fact that it is in their own interests to provide resources and information systems that will support the development of their workforce. We recognise the reality that resources available for CPD are likely to come under pressure in times of economic downturn, but we have no statutory powers to force employers to allocate particular resources. However, embedding our guidance in local processes of appraisal, in the guidance for Responsible Officers and in the guidance of the systems regulators will help make our expectations clear. The introduction of revalidation will provide a further lever in that it will enable us to focus on the outcomes for which CPD is an input and identify where there are institutional problems.

70. It is unrealistic to imagine that CPD can be divorced from service needs (or the needs of the employers who are being asked to fund it) because these are also, to a significant degree, the needs of patients and the public. But there is a balance to be struck between immediate service needs and longer term developmental needs of individuals. The place for discussion of this is within appraisal and not national prescription by the regulator.

71. However, none of this should detract from doctors’ own responsibility for their personal learning as emphasised at the start of our new guidance.

Question 6 – Barriers faced by employers

72. We asked ‘Do you think there are any barriers stopping employers and contractors from carrying out their responsibilities?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>52</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Organisations</td>
<td>33</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85 (76%)</strong></td>
<td><strong>18 (16%)</strong></td>
<td><strong>9 (8%)</strong></td>
</tr>
</tbody>
</table>

73. The majority of organisations and individuals (76%) agreed there were barriers for employers carrying out their responsibilities in relation to CPD.

74. The most common barrier identified was pressure on funding and, often linked to this, pressure on time and the demands of the service. Several commentators noted that workplace training unrelated to professional roles was sometimes misused for CPD.

‘Service needs and the need for Trusts to seek sufficient funding and income streams may conflict with a doctor’s wish to develop services based on patient need or to seek improvements in service delivery which may require...’
additional funding etc. These considerations should not be ‘resource' led.’
(Medical and Dental Defense Union of Scotland)

‘Current inconsistency among employers in provision of time and resources for CPD may worsen with withdrawal of support where there are severe financial constraints.’ (Care Quality Commission)

75. Respondents also highlighted difficulties faced by particular groups such as private practitioners, doctors contracted by organisations, locums and sessional GPs. These doctors are often expected to pay for CPD personally and undertake learning activities on their own time:

‘Many non-NHS employers/contractors (and some NHS ones) are facing very stringent financial constraints. The costs to an organisation of providing or supporting CPD (even if only providing study leave) are significant. The reality, particularly for contractors, is that they are likely to simply see CPD as the doctor's responsibility, and not one in which they are likely to invest any real resource.’ (Faculty of Forensic and Legal Medicine).

Our response

76. As the answers to questions 5 and 6 show, there was significant concern that the proposed role for the GMC would not put sufficient pressure on employers to make CPD resources available. In paragraphs 69 -70 above we comment on how our guidance will make clear our expectations of those who employ or contract doctors’ services. However, this should not detract from doctors own responsibility for their personal learning as emphasised at the start of our new guidance.

Question 7 – Use of CPD in revalidation

77. We asked ‘Does the guidance provide sufficient information about the use of CPD to support revalidation? If not, what further information would be helpful?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>57</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Organisations</td>
<td>23</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>80 (71%)</td>
<td>22 (20%)</td>
<td>10 (9%)</td>
</tr>
</tbody>
</table>

78. 71% of all respondents said the guidance provided sufficient information on the use of CPD to support for revalidation. This was combined with overall satisfaction at the generic nature and flexibility of the guidance. A few responses also welcomed the requirement for doctors to follow advice from their medical Royal College or specialist organisation.
79. Respondents who disagreed with our proposals generally called for more specific information about the amount of CPD required for revalidation. A few responses suggested that more detailed information would help to ensure that the guidance was interpreted by appraisers in a consistent way.

‘A doctor participating in revalidation will wish to understand the basis to the decision of a Responsible Officer. CPD is an input. More detailed guidance on information about CPD which is likely to result in a positive decision, and importantly, a negative decision by a Responsible Officer would be useful. It is recognised, however, that there is a clear tension between detailed guidance and “industrialisation” of CPD.’ (Medical Council of Ireland)

80. The difficulties faced by particular groups of doctors were again highlighted. Part-time workers, doctors on career breaks and those not in conventional clinical settings were among those who it was felt might struggle to provide sufficient CPD for revalidation. For these doctors specific guidance was felt to be useful:

‘The guidance is primarily helping doctors currently working in traditional medical employment; it mentions only cursorily how doctors taking career breaks, which may not always be planned, should plan their CPD to maintain revalidation. In acknowledging the role of the workplace in experiential learning, the guidance gives little help in determining substitutes to those currently out of the workplace for various reasons.’ (Doctor)

Our response

81. Although there were calls for further guidance to support doctors in part time roles, the majority of respondents were content with our guidance on CPD in revalidation. The principles it sets out are applicable for all doctors, not just those in full-time and traditional roles. Further more detailed guidance for doctors and Responsible Officers on the revalidation process and how recommendations to the GMC are made is currently being developed as part of the preparation for the introduction of revalidation at the end of 2012.

What people said about embedding CPD in local processes

82. In order to be effective, the framework of principles and guidance we had developed needs to be incorporated within local processes. We identified appraisal and job planning as the best mechanisms for doing this.

Question 8 – Embedding the guidance

83. We asked ‘Do you think we have identified the most effective ways of embedding the guidance into local processes?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>41</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>Organisations</td>
<td>27</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>
84. The majority of postgraduate medical institutions, NHS/HSC organisations and bodies representing doctors as well as over half of individual doctors supported our approach. There was also recognition of the need to work with others to achieve this:

‘Yes, given that there are limitations on the legal powers of the GMC in this regard (para 85). It would represent a retrograde step if the regulator was to prescribe the content and nature of CPD provision, and it would be unrealistic to do this for every specialty...there is the opportunity for the GMC to work closely with the bodies responsible for organisational effectiveness for revalidation and with the systems regulators to ensure that employers and responsible officers have appropriate support in place.’ (AoMRC).

85. Importantly, there was support from NHS Employers:

‘We agree that it will be important to embed GMC guidance into local processes and appraisal systems so that all doctors are supported in their CPD activity. Job planning, in which organisational, team and individual objectives are aligned will be an important means of ensuring the CPD activity and, crucially, the outcome of that activity, meets the needs of both individual doctors and the service.’ (NHS Employers)

86. Several responses recognised the central role of Responsible Officers (ROs) in supporting CPD provision locally and endorsed plans to embed our CPD guidance within the guidance for ROs. But respondents asked for more clarity on how Responsible Officers and appraisers will fulfil their roles and how the GMC will work with the systems regulators to ensure that organisations are making adequate provision for CPD.

‘The RCPCH understands the regulatory limits of the GMC as set out and agrees that embedding requirements via other regulators is appropriate. The GMC may nevertheless provide recommendations to regulators of health organisations. For instance, were a pattern to emerge of doctors in a particular organisation failing to revalidate because of a deficit in CPD, it would be desirable for the Responsible Officer to be required to provide evidence of the organisational support for CPD for doctors.’ (Royal College of Paediatrics and Child Health)

87. The BMA, two postgraduate medical institutions and the Patients’ Association argued that mandatory CPD requirements were the best way to embed CPD, coupled with monitoring of compliance. This was echoed in the feedback from the consultation events where some participants questioned how we will quality assure the use of the guidance.

‘[T]here is a view that the GMC should more robustly outline the requirements that employers need to meet in order to embed CPD into local processes. The
guidance suggests that ‘the GMC has no legal power to impose requirements on other organisations in relation to CPD’ but this places doctors in a very difficult position at a time when employers are seeking to make efficiency savings. …[The consultation] however does not explain how CPD will be embedded in local processes, or the mechanism that the GMC proposes to achieve this aim. Further detail is required on the work that the GMC will undertake with the other system regulators and employer organisations.’  
(BMA)

Our response

88. We aim to have reference to our guidance included in documentation for appraisal and for Responsible Officers. We will also use our new Employer Liaison Advisory Service and Regional Liaison Officers to ensure that the guidance is highlighted within local processes. The introduction of revalidation will provide a further lever in that it will enable us to focus on the outcomes for which CPD is an input and identify where there may be systemic problems within organisations. We will also wish to evaluate the value added by our approach to CPD overall.

What people said about our plans to share what we know

89. We proposed that the GMC should not, in general, be a provider of CPD for doctors. 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.

Question 9 – Sharing information about trends

90. We asked ‘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?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>58</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Organisations</td>
<td>39</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>97 (87%)</td>
<td>11 (10%)</td>
<td>3 (3%)</td>
</tr>
</tbody>
</table>

91. Most respondents supported a role for the GMC in providing information about trends and developments that may help doctors reflect on their learning needs. The AoMRC, all of the NHS/HSC respondents and most of the postgraduate medical institutions endorsed our plans. Similarly, most doctors, medical managers and members of the public thought this would be useful.
‘Yes, many doctors find regular GMC updates useful’ (BMA)

‘We think that this process will benefit from research information on the links between poor performance and CPD activity’ (NHS Employers)

‘May demonstrate trends at both local and national level that the GMC should respond to’ (London Deanery).

92. Respondents identified a number of areas where we could add value. These included providing guidance on ethical issues and changes in public attitudes affecting medical practice, recurrent themes in cases of poor practice and guidance on professionalism. However, there was concern that the GMC should not go beyond its areas of expertise

‘The GMC has expertise in certain areas of professionalism and could reasonably offer educational activities in these areas – but they would be limited to consideration of elements of Good Medical Practice, Confidentiality, Medical Ethics and Medical Regulation itself, all of which are important’. (AoMRC and FRCP)

93. A small minority felt that by providing information and support on CPD we would be going beyond our remit. Others voiced concern about the proposal to use the GMC database to target information to individual doctors’ which may be relevant to their learning needs. In particular, there was doubt that the GMC database would be sufficiently up to date to reflect doctors’ current needs.

‘Medicine is evolving too quickly for the GMC to highlight emerging trends and developments in medical practice using the GMC database’. (Royal College of Physicians of Edinburgh)

Our response

94. There is clear support for the GMC providing information about research, trends and developments in professional practice which may assist doctors in reflecting on their CPD needs. At the same time, we need to be clear about where we can add value and where it is better for others to lead. We will need to develop this role carefully and pilot any new initiatives. However, the publication in 2011 of the State of Medical Education and Practice is one example of how we might start to develop our role in a way which supports reflection by others rather than imposing regulatory prescription.

How our plans will affect groups of doctors

95. Our guidance emphasises that both doctors and employers have responsibilities in relation to CPD. We wanted to know if our plans would help doctors access appropriate CPD more easily. We were particularly interested in the effects for groups such as locums, SAS grade doctors, sessional GPs, doctors in less than full-time practice and those planning or returning from career breaks.

Question 10 – Promoting recognition of doctors’ CPD needs
96. We asked ‘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?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>49</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Organisations</td>
<td>35</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>84 (80%)</strong></td>
<td><strong>11 (10%)</strong></td>
<td><strong>11 (10%)</strong></td>
</tr>
</tbody>
</table>

97. Most organisations, including the BMA, AoMRC, NHS Employers and the Patients’ Association as well as the majority of individuals, endorsed our plans. However, this support was often conditional upon us addressing concerns raised elsewhere in the consultation. These included providing greater clarity on the duties of employers, how our guidance will be embedded into local processes, how we will ensure access for all doctors to CPD and the need for stronger links to, and recognition of the role of, the medical Royal Colleges. We acknowledge the importance of working with the Colleges (which have considerable expertise in this area), including the need to support access to CPD for doctors who are not part of College schemes. We will also need to work with employer organisations to ensure that the principles contained in our guidance become part of local processes.

98. Respondents who did not think our proposals would help recognition of doctors’ CPD needs were asked how we might do this better. The Royal College of Anaesthetists commented that if the guidance was successfully embedded into local processes it should benefit all doctors ‘including those from groups whose CPD needs, in many cases, have often been under recognised by employers’. However, it also felt that the GMC should do more to highlight the ‘obligations owed by employers to those doctors working part-time or in remote/rural areas, small hospitals and non-consultant career grades’.

99. BMJ Learning responded that the GMC should ‘consider further how best it could support doctors who are not part of a college, specialty or professional association network’. Another respondent wrote of the need to be ‘careful not to marginalise part-time doctors, many of whom are women’. The MDU referred to the needs of doctors ‘who have been suspended and who are returning to work’.

100. NHS Employers said that guidance should focus on the importance of CPD for all doctors, including those not working in established, well managed settings. It added:

> ‘As the report points out it will need to be responsive to the fast changing structural environment and meet the needs of emerging groups such as those consultants who retire and subsequently return to practice.’ (NHS Employers)
101. A individual respondent wanted more research on why some doctors fail to get access to CPD

‘The reasons why some doctors cannot access CPD activities needs to be studied better and based on results from these studies the GMC could advise the doctors and employers’ (individual doctor)

Question 11 – Adverse effect on groups of doctors

102. We asked ‘Are there any groups of doctors upon whom our proposals might have an adverse effect?’

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>19</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>Organisations</td>
<td>17</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36 (35%)</strong></td>
<td><strong>41 (40%)</strong></td>
<td><strong>25 (25%)</strong></td>
</tr>
</tbody>
</table>

103. Opinion was split on whether the guidance would have an adverse effect on any particular group of doctors. However, respondents’ comments did not suggest that our proposals would have an adverse effect on particular groups, but rather that more needed to be done to support some groups.

‘Numbers of sessional doctors will increase under proposed NHS structures, and unless processes are developed for their CPD there is a growing danger that they could be marginalised… by not taking a clear position on Colleges’ approach to CPD credits, the GMC fails to resolve uncertainty over what level CPD activity should be expected of part-time GPs’ (RCGP).

‘it is still unclear how doctors with no clinical practice are to be treated’ (BUPA).

104. There was slight concern about the section in the guidance entitled ‘reflecting on your practice’. The BMA commented that the guidance:

‘assumes that the doctor works in a managed organisation, which is not the case for doctors such as peripatetic locums. It can be very challenging for this group of doctors to participate in audit as they tend not to be involved by practices in significant event audits, complaints or compliments. Whilst peer review can be managed by being involved in learning groups or sets, it is important that the tools needed to facilitate development are sufficiently flexible to accommodate this.’

105. Other groups identified as facing particular problems included SAS grade doctors, locums, those in part-time practice, doctors taking career breaks, doctors on maternity leave and those raising children. In particular, the implications for women were noted by many.
'It is important to maintain flexibility in the ways that CPD is obtained, and to recognise a wide range of learning opportunities. In particular the position of female doctors should be considered as they tend to be the majority of part time workers but have to do the same amount of CPD, and have significant periods of maternity leave when they will have to make up their CPD requirements or defer revalidation? Secondly, while there may not be as direct an adverse effect, there could be a lack of intended benefit.' (FRCP)

106. The Medical Protection Society felt that some doctors would struggle to meet our expectations on reflection, particularly ‘those who have been in practice for many years and have not been used to recording reflections on their learning activities’.

General comments about the consultation

107. We asked respondents if they had any further comments on the conclusions of the review report and the report recommendations. Overall, respondents used this opportunity to endorse our proposals. However, many commentators went on to reiterate themes such as the need for mandatory CPD requirements or raise concerns that some groups of doctors find accessing resources for CPD challenging.

108. Some agreed that research into the link between CPD and fitness to practise would be valuable. They suggested that the focus should be on ways that CPD improves performance and addresses concerns rather than the links between inadequate CPD and poor medical practice.

Conclusions

109. In our consultation we proposed developing the GMC’s role in CPD in three ways:

- Introducing new guidance setting out principles for how doctors should plan, carry out and evaluate their CPD.
- Working with employers to ensure that CPD and our principles are embedded in local processes.
- Adopting a new facilitative role intended to bring information to doctors’ attention to inform reflection on their CPD needs.

110. Our approach was intended to make clear that the principal aim of CPD activity must be to improve the safety and care provided to patients and the public. We also recognised that as professionals the primary responsibility for planning, undertaking and evaluating doctors’ CPD rests with doctors’ themselves. At the same time, others have a responsibility and an interest in supporting them to do this. The GMC has a role in supporting doctors’ CPD, but it is not the only body. We need to be clear where we can add value and where others, such as Colleges, specialist societies, employers and doctors themselves are better placed to lead.

111. The response to our consultation confirms that our overall approach is the correct one. We received strong support for the framework of principles provided by
our draft guidance. Although a significant number of respondents felt that we should be more prescriptive in terms of the content or quantity of doctors’ CPD activity, the disadvantages are likely to outweigh the advantages. Prescription might provide certainty about the GMC’s requirements, but for most doctors those requirements could never be sufficiently nuanced to meet their individual needs or the needs of their patients.

112. Before imposing requirements we also need to be clear how we would enforce them. We should support doctors by encouraging them to focus on the outcomes of their CPD not counting the number of hours input. Some respondents have told us that only by prescribing CPD hours or credits can we give doctors the leverage they need to negotiate CPD resources from employers. This would be the wrong lever for us to pull and, in the absence of legal or contractual power over employers, it is unlikely to be effective. Instead, it is the lever of revalidation which will help ‘support delivery of robust arrangements for CPD.’

113. Respondents supported our plans to provide information about trends and developments that may help doctors reflect on their learning needs. There were questions about whether those plans go far enough or too far and beyond our proper regulatory remit. We should therefore develop our role gradually to ensure that new initiatives add value which others cannot provide. But, at the very least, it may allow us to highlight some of those areas of learning about which we would not want to be prescriptive, but upon which individual doctors may need to reflect for the benefit of their own development and for the benefit of their patients.

---

1 Lord Darzi, A High Quality Workforce: NHS Next Stage Review, 2008, p137