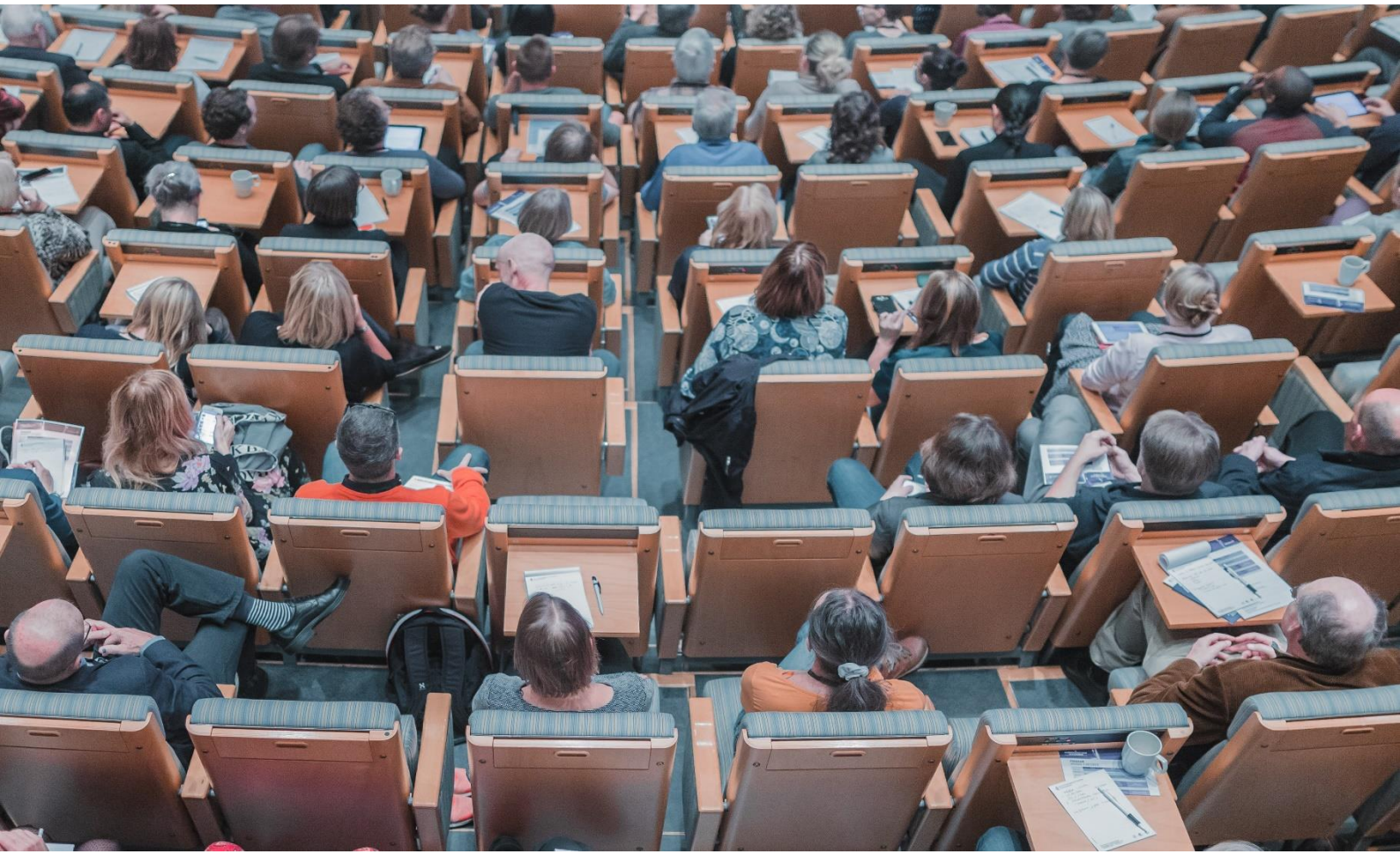
How lifelong learning for doctors is valued, managed and supported in the UK

A research report for the GMC
September 2021

community research

Bringing the voices of communities into the heart of organisations



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1. Executive summary

1.1 Background and methodology

This research was commissioned to help the General Medical Council (GMC) understand the way lifelong learning, including Continuous Professional Development (CPD), for doctors in the UK is valued, managed and supported by employers and stakeholders. The methodology comprised two separate stages, a rapid literature review of issues relating to lifelong learning (the report can be found in the appendices to this report), followed by a series of individual interviews with:

- 25 employers (including representatives of secondary care and community trusts and GP Partners).
- 15 stakeholders and academics with oversight of, or an interest in, lifelong learning.

1.2 Overview of findings

Continual Professional Development (CPD) rather than lifelong learning was the term most frequently used by employers, stakeholders and academics. However, some appreciated that lifelong learning enjoyed a broader interpretation than CPD - more inclusive of doctors at all career stages and with the potential to represent all forms of learning. Regardless of the term used, lifelong learning was reported to be valued by employers as a concept, even if this did not always translate to practice.

There were no specific, separate written strategies reported to be in place for lifelong learning at an organisational level and the direction of lifelong learning was generally believed to be determined by individual doctors, with input from appraisers. The appraisal process was also relied upon to ensure the effectiveness of lifelong learning as employing organisations did not generally measure the overall effectiveness of lifelong learning for the doctors they employed.

That said, secondary and community care trusts did have processes in place for funding and study time to facilitate lifelong learning and they provided and monitored mandatory training. In primary care, mandatory training was also provided but funding and study time appeared to be less of a given, at practice level, with most of those interviewed believing GPs used their own time and money to keep up to date. All employing organisations reported offering an array of in-house learning opportunities from clinical updates and grand rounds through to lunchtime learning sessions. Processes in place to support lifelong learning were broadly similar across the UK.

Whether learning was provided in-house or sought from external organisations, several points were raised in relation to the content and format of lifelong learning:

- **Doctors often focus on clinical skills:** Individual doctors are more likely to focus on clinical skills early in their career and/or when learning time is 'squeezed';

whilst, later in their careers they may display more eclectic tastes and a greater interest in leadership.

- **A need for greater emphasis on everyday learning encounters:** Everyday learning encounters are valued, but there is a perception that doctors do not always have the confidence or means of recording this type of learning for appraisal and revalidation.
- **Multi-Disciplinary Team learning can help drive change:** Multi-Disciplinary Team (MDT) learning is welcomed as it is believed to help drive change (because all professions have the opportunity to buy into the learning and potential improvements).

Overall, the current approach to lifelong learning was appreciated for allowing doctors to determine the direction of their own learning (albeit influenced and/or supported by other players, including appraisers as well as external organisations, such as the Medical Royal Colleges and the GMC). However, there were also several potential issues associated with the current system:

- Dominance of CPD points and lack of clarity about the role they played in appraisal and revalidation.
- Recording of lifelong learning (in particular duplicate recording and the perception that everyday learning opportunities were more difficult to record).
- Reliance on the appraiser-appraisee relationship to help direct and evaluate lifelong learning.
- A lack of certainty that current approaches to lifelong learning are addressing future needs.

There were also thought to be numerous barriers to lifelong learning facing doctors. These were associated with the individual (attitude to learning, life-stage, working part-time, language), the role they worked in (with SAS, LED, locums and self-employed doctors in the private sector facing particular challenges) and organisations (service demands, specialty, culture, location, funding, facilities). However, the overarching barrier to doctors engaging with lifelong learning was lack of time, in large part driven by service demands.

COVID-19 was believed to have impacted both positively and negatively on lifelong learning for doctors. Perceived positives were: increased access to online learning opportunities (this appeared to have been a particular benefit for doctors based in the devolved nations and/or rural areas who previously had to make significant journeys to attend meetings/events); facilitation of team-working; greater opportunity to reflect on everyday learning opportunities. Perceived negatives were: lack of time for CPD; the dominance of COVID related learning; reduction of Protected Learning Time (PLT) sessions in primary care; limited clinical opportunities (particularly affecting those in key transition roles); lack of formal and informal networking opportunities.

Going forward, there was little appetite amongst employers, stakeholders and academics for the GMC to extend its role in lifelong learning beyond offering guidance and influencing the direction of, and messaging around, lifelong learning. There were several suggestions made:

- Greater emphasis on everyday learning opportunities.
- Outlining good practice for mandatory training.
- Emphasising team working.
- Potentially offering more guidance for appraisers/appraisal leads.
- Potentially offering more guidance around reflection.
- Working with other organisations to communicate a consistent message around lifelong learning.
- Being vocal about the importance of lifelong learning - for all doctors - to help ensure learning time is given and not compromised.
- Ensuring the right tone around lifelong learning, this could include addressing doctors' concerns/fears around reflection and building on the changes to the appraisal process brought in as a result of the pandemic.

2. Background, objectives and methodology

2.1 Background and objectives

This research was commissioned to help the General Medical Council (GMC) understand the way lifelong learning, including Continuous Professional Development (CPD), for **doctors not in a training programme** in the UK is valued, managed and supported by employers and stakeholders. More specifically it set out to answer four key questions:

- What processes are used to manage and support lifelong learning for doctors (pre-COVID-19)?
- To what extent is lifelong learning for doctors valued by doctors, employers and other stakeholders?
- How effective do doctors and employers consider lifelong learning and CPD both prior to and during the COVID-19 pandemic?
- What, if anything, has changed in the approach to lifelong learning as a result of the response to COVID-19?

2.2 Methodology

2.2.1 Overview of the approach

The methodology comprised a rapid literature review of issues relating to lifelong learning, followed by a series of individual interviews with employers (including GP Partners) who had some responsibility and or/oversight of lifelong learning for doctors not in a training programme, stakeholders and academics with an interest in lifelong learning.

2.2.2 Rapid literature review

The purpose of the rapid literature review was to identify available evidence on employer perspectives of the current situation in relation to lifelong learning for doctors in the UK, and to use this information to inform the development of a programme of qualitative research. The review was conducted by Community Research's academic partners Dr Jean Ledger and Dr Cecilia Vindrola-Padros.

The literature review findings can be found in appendices to this report.

2.2.3 Individual interviews

With employers

In total, 25 interviews with employers were conducted:

- 8 x GP Partners
- 17 x representatives of NHS trusts/health boards (including Medical Directors, Responsible Officers, Directors of Medical Education, Appraisal Leads)

Interviews with employers were recruited to an agreed specification, with quotas on several variables including country and setting.

Employers working in secondary and community care were recruited by a direct email approach to Responsible Officers[1], who were then asked to identify the most appropriate individual within the trust to interview. In some cases, this was the Responsible Officer themselves but, in other cases, the Director of Medical Education and Appraiser Leads were interviewed. The research was further highlighted in a newsletter that is circulated to Responsible Officers so that anyone interested could express their willingness to take part.

GP Partners were recruited by Acumen Fieldwork to an agreed specification. This recruitment approach involved offering GPs an incentive for participating.

A full profile of all employers is provided in Appendix D (within the appendices document) with participants also representing a mix by gender, size of practice, country and urban/rural.

With expert academics and stakeholder organisations

- 9 stakeholders who were involved in delivering medical education and/or had an interest in lifelong learning.
- 6 expert academics with an interest in lifelong learning.

The academics were partially identified through the literature review and selected on the basis of their having expertise in the field of lifelong learning (with judgements made on the recency of publications and the posts held). Stakeholder organisations were selected from across the four countries to ensure views came from the devolved nations as well as England. They included Royal Colleges, membership and employer organisations, defence organisations and organisations focussing on health education and training.

Expert academics and stakeholder organisations were not offered an incentive for taking part.

2.2.4 Fieldwork process

All interviews were conducted during the COVID-19 pandemic and discussions explored how lifelong learning was valued, managed and supported both before and during the pandemic. The fieldwork period ran from 14th April until 24th June 2021.

The interviews followed a semi-structured guide in order to allow participants to elaborate on and discuss their views and perceptions freely. All interviews were

[1] Responsible Officers are the individuals within designated bodies who have overall responsibility for employed doctors' revalidation.

conducted by Community Research. The interviews were audio recorded and transcribed. The discussion guides used are provided in the appendices to this report.

2.3 Notes on reading the report

There are a number of caveats to bear in mind when considering the research findings.

- It is worth noting that the employers who participated in this research 'opted in' to the process and actively responded to communication about the research saying that they were willing to participate. It could be that those who opted into the process are different in some way (in terms of their experience or views of lifelong learning) than the wider sample of employers eligible to participate.
- Stakeholders and employers had differing levels of oversight and involvement in lifelong learning. This makes it more challenging to establish a comprehensive and in-depth picture for all the employers represented, as not all those interviewed had detailed knowledge of every aspect of organisational support for lifelong learning.
- That said, it is also important to note that qualitative research is not intended to be statistically reliable and, as such, does not permit conclusions to be drawn about the extent to which something is true for the wider population.
- Finally, many of the employer, academic and stakeholder interviewees were doctors themselves and, it is somewhat inevitable that their views were influenced by their individual experience of, and attitudes, towards lifelong learning.

Throughout the report, quotes have been included to illustrate particular viewpoints. It is important to remember that the views expressed do not always represent the views of all who participated. In general, however, quotes have been included to illustrate where there was particular strength of feeling about a topic. Quotes have been attributed slightly differently for the various audiences, to protect the anonymity of those who took part. For example, academic and stakeholder participants are numbered and quote attributions for employers from devolved nations do not include the job title given the smaller number of employers and the increasing likelihood of individuals being identified.

Note that any examples given are for illustrative purposes only and are not intended to make a positive or negative judgement on what is happening within organisations.

3. Context setting

Section summary

Continuing Professional Development (CPD) rather than lifelong learning was the term most frequently used by employers, stakeholders and academics; however, some appreciated that lifelong learning may have a broader interpretation than CPD.

Regardless of the term used, lifelong learning was reported to be valued by employers as a concept, even if this did not always translate to practice.

3.1 Language used

The research briefly explored the terms used by employers, stakeholders and academics in relation to educational and training approaches for doctors beyond training grades.

Continuing Professional Development (CPD)

CPD was reported to be the term most frequently used by employer organisations for two reasons:

- It reflected the language used within the appraisal and revalidation process (often further reflected within job planning) that employers and employees were familiar with (and is the terminology used by the GMC in this respect).
- The term was relevant to a broad range of healthcare professionals, not just doctors.

Although widely used, employers, stakeholders and academics highlighted that CPD had become synonymous with the collection of 'points'[2] and, what doctors negatively perceived to be, the onerous nature of appraisal and revalidation. Furthermore, several of those interviewed felt that CPD was more closely aligned with doctors who had completed training and, therefore, may not represent the journey of learning that starts with undergraduate education.

> If I say to someone 'CPD' then they understand exactly what I mean. Lifelong learning can be talking about lots of different things which don't necessarily

[2] Most medical royal colleges and faculties have developed CPD schemes or guidance to support doctors in maintaining and developing their professional standards in their specialty. The colleges and faculties require doctors participating in these schemes to obtain a specified number of CPD credits over five years

> relate or pertain directly to your professional education as it were. (GP Partner, more than 10 salaried GPs, South, England)

Continuing Medical Education (CME)

Employers, stakeholders and academics agreed that CME was not commonly used across primary, secondary or community care. They explained that:

- 'Education' was more associated with undergraduates and postgraduates rather than doctors who had completed training.
- 'Medical' related to doctors and did not sit well within organisations managing a multi-professional workforce.

> They might as well use the term 'CPD' because CME has definitely been rejected here for all sorts of reasons. I think they might as well continue to talk about CPD because it is the common parlance now. (Academic 1)

Lifelong learning

The term lifelong learning was welcomed by a number of employers, stakeholders and academics, even though it was not as commonly used as CPD.

- It reflects a learning journey spanning a doctor's entire career.
- It recognises the whole individual and not just the professional.
  - Although this was a negative for some.
- It does not have the negative link to 'points'.
- It has the potential to capture a broad spectrum of learning opportunities.
  - CPD, with its association to points, was often more closely associated to formal learning opportunities such as courses and conferences.

> We probably tend to use the word CPD, Continuing Professional Development, the most in our context because that's what the GMC refer to in their supporting information for appraisal and revalidation. But I really like the term 'lifelong learning', I think that's a good term as well. I think any learning is good learning, it doesn't have to be a formal course, a formal webinar, it could be a discussion with a colleague. And I like the idea that it's for life, it's a journey, one's always learning. (Stakeholder 14)

However, ultimately, it was the principle of lifelong learning and not its label that was believed to be central to professionalism.

> I guess it's the acceptance by the organisation and individuals that you're always learning new things throughout your career. I think that's the significant thing, not necessarily the name you give to it. (Responsible Officer, NHS Acute Trust, Midlands, England)

3.2 The value of lifelong learning

Lifelong learning was believed to be deeply embedded within the medical profession

and the principle, if not the practice, much valued by employers and doctors themselves.

> I can't think of anybody I have ever met who, as a professional, doesn't have a core tenet of their professionalism that they keep up to date with what they do. (Stakeholder 6)

Some employers, stakeholders and academics also suggested that lifelong learning was of specific value to ensuring the resilience of doctors; allowing doctors the opportunity to step away from the pressures of their clinical work. One or two employers added that promoting lifelong learning could also aid recruitment strategies.

> There should be something that is fun about going on a course, because in terms of building up your resilience and all those positive things, it's not just learning it, it's a day away from the office. (Deputy Medical Director, NHS Acute Trust, North, England)

> It's a structural way of the NHS saying we actually care about you and your development and your mental health and for the next 35 years you're going to work for us in a constructive way. (Academic 3)

Although the principle of lifelong learning was valued, most of those who took part in the research believed that this did not always translate to practice. They pointed to:

- The prioritisation of service needs over learning (occurring even before the COVID-19 pandemic).
- The dominance of mandatory training and organisational compliance over broader elements of lifelong learning.
- A reduction in training budgets.

> Within a board level we can say that we give you four hours per week on your CPD, but the reality is that my job is so busy, I don't have those four hours to give to CPD. Whose responsibility is that? Well, that comes down to job planning and ensuring that there is adequate staff and that people have the time to feel that they can take it and be valued in their learning, to then be able to bring that back to service and that learning is valued. The fact that they can't, would suggest that maybe it's less valued. (NHS Health Board, Scotland)

> They see it as something they want their staff to engage in, but when it comes down to the hard facts, are they going to give them time off to do this? Are they going to fund their expenses to do it? They tend to revert to saying: "What is it you have to do? How many hours do you need? What are the life support courses that you have to do? Which certificates do you have to have? Those are the things that we will support you in doing". (Academic 2)

3.3 Accountability and responsibility

There was an almost universal belief that individual doctors of all levels were responsible and accountable for their own lifelong learning.

> I don't think you can ever say anybody has accountability apart from me. It's individual for my own lifelong learning, and the reason I say that is because nobody else can know what I don't know. (Stakeholder 6)

> Caring for Doctors, Caring for Patients[3]. So, there is the ABC and I think CPD falls into the A, the Autonomy. (Responsible Officer, NHS Acute Trust, North, England)

That said, employing organisations, the Medical Royal Colleges and the GMC were thought to have responsibility for specific aspects underpinning lifelong learning for doctors not in training programmes:

- For the most part, the Medical Royal Colleges and the GMC were seen to set standards for lifelong learning, either at a high level or a profession specific level.
- Employing organisations were believed to hold a number of responsibilities in terms of the facilitation of lifelong learning. **These will be explored in the next section.**

[3]The document referred to is: https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf This document refers to 'the ABC of doctors' core needs'.

4. Lifelong learning at an organisational level: Understanding the processes

Section summary

There were no separate formal written strategies thought to be in place for lifelong learning at an organisational level. Whilst lifelong learning was referenced in various strategy documents, the direction of lifelong learning was generally believed to be determined by individual doctors, with input from appraisers. The appraisal process was also relied upon to ensure the effectiveness of lifelong learning.

That said, secondary care trusts/heath boards had processes in place for providing funding and study time to facilitate lifelong learning and they provided and monitored mandatory training. In primary care, processes to support lifelong learning were more varied but funding and study time appeared to be less of a given at practice level, with most of those interviewed reporting that GPs used their own time and money to keep up to date. However, doctors working in primary care did benefit from Clinical Commissioning Group (CCG) and health board funding for Protected Learning Time (PLT) for practice team-wide learning. Although, again, there was some variation across locations. Practices also provided and monitored mandatory training.

All employing organisations reported offering a diverse range of in-house learning opportunities. The provision, format and content of these learning opportunities is explored in Section 5.

4.1 Formal strategies for lifelong learning

No employer referred directly to a separate organisational strategy for lifelong learning, rather lifelong learning was thought to be referenced within other strategy documents (for example, those relating to workforce, organisational culture, organisational development, new service development etc.) and organisational guidance (relating to appraisal, job planning, personal development plans).

> So, getting your head around lifelong learning at a broader, corporate level.. …there are little pockets of it here and there within the organisation but, as a theme and a strategy, we are a long way away from it. (Deputy Medical Director, NHS Acute Trust, North, England)

4.2 Responsibility and accountability for lifelong learning within employing organisations

Within primary, secondary and community care organisations oversight of, and accountability for, lifelong learning for doctors not in training programmes, rarely sat with one individual.

- In primary care such oversight involved several GP Partners, often alongside the practice manager.
- Within secondary and community care trusts, oversight was more dispersed amongst:
  - Directors of Medical Education
  - ROs and Appraisal Leads
  - Clinical Directors
  - Medical Directors and CEO

> I am also the Director of Medical Education there. Which means that my primary concern is our non-consultant doctors; but I am also in-part responsible for education relating to consultants; and I am certainly responsible for the learning and training and progression of doctors who might be with us for their entire careers but don't aim for a consultant post, so what we call locally employed doctors. (Director of Medical Education, NHS Acute Trust, South, England)

Several employers and stakeholders acknowledged that there was far less accountability and oversight for the lifelong learning of doctors not in training programmes, compared to the education and training of trainee doctors.

> I think at the moment it feels to me as if learning for doctors who are not trainees kind of runs itself with no oversight as to whether (a) we're getting value for money, which I think is important, (b) whether it's really achieving what it set out to do, which is to make sure doctors are engaged in lifelong learning. I don't think I could assure our board, at this point in time, what we're getting out of it really. I could do that for junior doctors. (Medical Director, NHS Acute Trust, North, England)

4.3 Influencing the direction of lifelong learning

For the most part, lifelong learning within primary, secondary and community care was thought to be directed by individual doctors (ideally with input from appraisers), rather than by the organisations they worked for.

> I can't speak for everybody, but I don't get the feeling that in many trusts there is more of a top-down oversight of what people use their study leave for. It has always been considered to be very much down to a discussion between the individual and their appraiser. (Director of Medical Education, NHS Acute Trust, South, England)

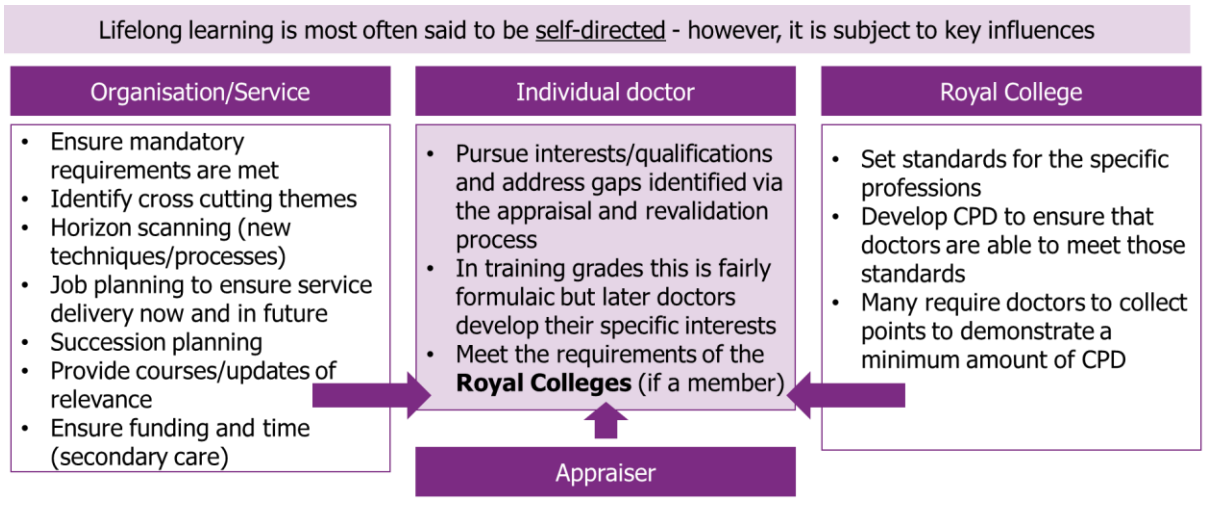
That said, although not directed by employers, lifelong learning was thought to be influenced by mandatory training; job planning; succession planning; quality improvement projects; and the identification and promotion of cross cutting organisational themes. In primary care, it was thought to be additionally influenced by 'business opportunities'.

> An individual Clinical Director might say: "Right, as a department we know that frailty units are coming down the line and that's what we want to work for - so will we need more consultant posts? or will we develop the consultants we've got to take those roles?" They would have discussions with their staff about who might want to take those roles and organise the development as part of that. So, some of the individual bits of the development agreement would go into appraisal, but actually the overall horizon scanning and the decision about where a department is going fits more in job planning. (Responsible Officer, NHS Acute Trust, North, England)

It was further believed that Medical Royal Colleges had a role to pay in the direction of lifelong learning by setting the standards required for the individual professions and providing guidance and resources to enable doctors to meet those standards. The role of Medical Royal Colleges is explored further in Section 7.

A summary of the influences on the direction of lifelong learning is given in Figure 1 below:

Figure 1 – Directing lifelong learning



4.4 Mandatory training

Few employers, stakeholders and academics spontaneously associated mandatory training with lifelong learning, in part because it was not believed to be a requirement of the GMC for appraisal and revalidation, with some doctors including it and others not. More typically, mandatory training was linked to organisational compliance.

> I think it's confused because the GMC say you don't need it, but then employers require it, but then that is down to organisational risk and that is for the organisations to make those decisions. They're the ones that will get the complaint, not the GMC. (Stakeholder 14)

Given its link to compliance, mandatory training was believed to be highly valued by organisations (although not necessarily by doctors themselves). Most employers reported investing in both the delivery and monitoring of mandatory training. Several employers outlined how they encouraged completion of mandatory training by:

- Linking it to eligibility for Clinical Excellence awards.
- Linking it to access to individual study budgets.

> I think that's quite an interesting question, what does the trust particularly value? I think in terms of the trust having a view, the only thing that they are particularly cited on is the compulsory statutory mandatory training. That's the thing on the dashboard, it's talked about and fussed about when the CQC are coming. I don't see dashboards saying x percentage of people have done leadership training, or safety training or whatever. (Associate Medical Director, NHS Acute Trust, South, England)

4.5 Funding and budgets for lifelong learning

4.5.1 In primary care

Within primary care the general perception amongst GP Partners, academics and stakeholders (with a background in general practice) was that lifelong learning was predominantly self-funded, and/or that GPs could take advantage of a number of free learning opportunities.

> There are lots of free resources out there but there are also some paid-for ones which are really worthwhile. A lot of people go on like 'hot topics' courses which are usually around £300. (GP Partner, less than 5 salaried GPs, Scotland)

> Probably half of your CPD has been done just by attending talks in the practice. In addition to that, most people do other mandatory training and other voluntary training. (GP Partner, more than 10 salaried GPs, South, England)

Certainly, no GP partner reported operating a specific training budget for doctors at a practice level. Instead, GP Partners explained how funding was sometimes available to doctors who wished to attend a specific training course that offered a potential business benefit to the practice.

> There is no budget that we would provide for people to train, unless it was a specific event. I think a few years ago we funded one of the partners to do the Dermatology Diploma, but they now work in the practice to provide those services. (GP Partner, 5-10 salaried GPs, North, England)

However, GP partners did talk about funding received from Clinical Commissioning Groups (CCGs) or Health Boards for Protected Learning Time (PLT). This money covered the costs of an out of hours service for an afternoon (once every one or two months) so that a practice (or group of practices) could run a learning session for all healthcare staff. The content of these sessions varied but examples included reviews of significant events and clinical audits; mandatory life support training; talks on specific conditions, such as diabetes. Often, topics were determined by the specific interests of the practice and/or individual doctors. One stakeholder further mentioned that the GPs in their area received a further £300 to cover the cost of employing a locum whilst attending an appraisal.

> I think everyone calls it something different [Protected Learning Time], which is the afternoon a month…they [the CCG] fund the Out of Hours service to cover the practices so that we can all get together. That is massively valuable. (GP Partner, 6-10 salaried GPs, North, England)

4.5.2 In secondary and community care

In contrast to primary care, there were several funding sources reported to be available to individual doctors working in secondary and community care for lifelong learning:

Individual study budgets

Doctors not on a training programme had access to a study budget, the amount of which was determined by individual trusts. The budget ran over a 3-year accounting period and trusts had different processes in place for doctors to be able to access it. Typically, requests had to be approved at a departmental level before being submitted to the Director of Medical Education to be signed off. The money was usually, but not exclusively, thought to be used for professional conferences and courses, taking exams, supporting educational and research interests. Several Directors of Medical Education highlighted how they 'rubber stamped' these requests rather than actively approving them.

Employers, stakeholders and academics (who may also have been practicing consultants) reported budgets ranging from £460 to £1,340 per annum for consultants. They were far less knowledgeable about the amount available to LED and SAS doctors:

- For LED doctors it was assumed to be less than the budget for a consultant, with some employers unsure if all LED doctors had access to a study budget at all.
- SAS doctors were thought to fare better than LED doctors with several reporting that the budget was on a par with consultants.

> I think we give our LEDs about £500 a year, which again some trusts don't do. (Director of Medical, Education, NHS Acute Trust, South, England)

> I should have made the point that I'm proud of the fact that the SAS doctors get the same allowance as consultants. I think that's a good thing because I want to see SAS doctors develop as well. (Medical Director, NHS Acute Trust, North, England)

Employers were not sure if these individual study budgets were ring-fenced or if they were absorbed into departmental budgets if underclaimed (the exception to this was a private provider). Several employers reported that they did not think the budget was well monitored and others suggested that the budget was not always fully utilised by doctors.

> But the way that that pot of money is allocated is moot because my understanding is that in most organisations it's not as if that money is ring-fenced or set aside particularly; it's just available in departmental budgets. Whilst people will pull you up if you over-claim, nobody is going to pull you up if you under-claim. You could be a doctor going through all of your five years of revalidation, never claiming a penny of that money, and so that money will presumably just disappear into the bottom line. (Director of Medical Education, NHS Acute Trust, South, England)

> Some departments are under the impression that there is a set amount, a budget, for each doctor and some don't think that. There is no clarity on what the situation is. (Responsible Officer, NHS Acute Trust, North, England)

Organisational and departmental funding for specific training

Mandatory training (and any training identified as necessary by the organisation or by a department/service) was not generally paid for by individual study budgets. Several employers explained that this could sometimes be a point of contention within the trust/health board.

> But any departmental needs would normally go through the Clinical Director and if there is something which is deemed to be really important it may well be funded separately. (NHS Health Board, Wales)

> So, we're putting together a programme [clinical leadership] for clinical directors and DMDs, and already it's a case of who pays for this? The trust is saying, "we'll have to take it out of the study budget." The doctors are saying, "No, this is something that the trust tells us to do, it's got to come from somewhere else." (Medical Director, NHS Acute Trust, North, England)

Endowments and bursaries

Several organisations cited either endowments (tied to a specific purpose) or bursaries as a means of funding training.

Self-funding

In addition to the funding available from the organisation, doctors were also reported to self-fund their lifelong learning to varying degrees; either to avoid the additional administrative task of applying for the study budget, or because they had already used their full allowance.

4.5.3 Conflicts of interest

There were few reports of conflicts of interest in the funding of lifelong learning within primary, secondary and community care. This was attributed to the transparency demanded by organisations (doctors having to record any possible conflicts of interest) and the reduced opportunities for drug companies to sponsor events, as a result to changes in the Association of the British Pharmaceutical Industry (ABPI) guidance.

> I think in the past that was true, some companies would sponsor events, but that's been drying up to a trickle now because things like formularies have been introduced across health boards, that doctors are much more restricted in what they can use. (Stakeholder 12)

Potential conflicts of interest were also thought to be difficult to prove. For example, one employer explained how, as Director of Medical Education, they would be unable to determine if the decision to use certain equipment in the hospital was a direct result of an equipment manufacturer paying for a consultant to attend a conference.

4.6 Time allocated for lifelong learning

4.6.1 In primary care

Within primary care there was no mention of GPs being given formal time within the working week to undertake lifelong learning (akin to Supporting Professional Activity); however, GP Partners did talk about annual study leave allowances. The way that study leave was managed varied by practice and was somewhat opaque. Approaches included:

- Allocating a number of days to be taken only for lifelong learning.
- Providing generous annual leave allowances with the assumption that any study leave required would be taken out of this.
- Additional study days provided at the discretion of GP Partners for learning that was of benefit to the practice.

> You get a week's study leave. In some practices doctors are only allowed to use that for study leave, whilst in other practices that can be rolled up in annual leave. So, I suppose it is nominally there. (GP Partner, less than 5 salaried GPs, Scotland)

4.6.2 In secondary and community care

Employers, stakeholders and academics reported that consultants, received both Supporting Professional Activities (SPA) time and a study leave allowance to allow them to maintain lifelong learning.

- SPA time was reported as being between 1 and 2 SPAs (4-8 hours) per week for consultants, with some employers explaining that completion of all mandatory training was expected to be undertaken within this.
- One employer further explained how, in their trust/health board, SPA time could not be moved or swapped and therefore was rarely utilised for formal courses (unless timings conveniently coincided).
- Study leave for consultants was consistently reported as 30 days over a 3-year accounting period (aligned to study budgets). Employers and stakeholders believed that not all doctors took their full allowance for study leave, and that study leave was used to take up formal, rather than make time for less formal, learning opportunities.

> The rule of thumb is that everybody gets 1½ SPAs, so that's six hours a week, for revalidation…..We won't ask any questions, but we expect that you are up-to-date with everything and you revalidate. (Deputy Medical Director, NHS Acute Trust, North, England)

Again, the situation for SAS doctors and LEDs was less clear, but the general perception was that LEDs had little or no SPA time built into their contracts and that, whilst there was national guidance for SPA time for SAS doctors, it was not always adhered to.

> If you have SAS doctors, who are the workhorses of their department, who do nine clinical patient facing sessions, then they don't tend to get 1½ SPAs for appraisal and revalidation. They should, the national guidance all says they should, but not every trust implements it. (Stakeholder 6)

> I think it's a bit more challenging for non-consultant staff….I think they have a smaller allowance for study leave. If you look at their job planning, a consultant is entitled to 1½ SPAs … But a non-consultant is only entitled to 1. (Responsible Officer, NHS Acute Trust, North, England)

Study leave for SAS and LEDs again varied by trust, with SAS doctors generally thought to be entitled to more than LEDs. However, there was lack of certainty amongst those who took part in the research about how exactly both study leave and SPA time worked for doctors who were not employed as consultants.

In both primary and secondary care any formal time allocated for lifelong learning was often eroded by service demands (more detail on this is provided in section 6.3). The processes/support for locums specifically, in relation to lifelong learning, are covered in Section 6.2.

4.7 How support for doctors differs to other healthcare professions

It was generally recognised that other healthcare professions did not receive the same support for lifelong learning as doctors. Several employers highlighted that this could cause tension within an organisation as other healthcare professions struggled to find the time to participate in lifelong learning opportunities; however, others believed that the different professions had their own routes and opportunities available for professional development and that these may have funding attached, for example nurses wishing to become Advanced Practitioners.

> The doctors find it much easier to access CPD than other staff do. The whole idea of revalidation is newer in nursing than medicine. If I want to go to the British Geriatrics Society [conference], I fill in the form and I book the time and there is a budget for it. But if the nursing staff want to go, it's much more difficult for them to get the time and the funding for it. (Responsible Officer, NHS Acute Trust, North, England)

4.8 Measuring effectiveness

Most employers reported that, as an organisation, they did not currently measure the overall effectiveness of lifelong learning but rather relied on individuals, supported by appraisers, to ensure that lifelong learning was effective. That said, several employers suggested that there may be more evaluation activity occurring at directorate level, without them being aware.

> And particularly in appraisal, a discussion around "Well you did this, what did you reflect? How have you changed your practice?" That should happen in the appraisal process. (Director of Medical Education, NHS Mental Health Trust, South, England)

Several suggested that effectiveness could potentially be measured by looking for reductions in the number of patient complaints; adverse events; or fitness to practise referrals; or possibly increases in staff retention rates. However, they further mused whether it would be possible to attribute any change to effectiveness of lifelong learning with any certainty, given that it would be difficult to isolate lifelong learning as a single variable.

> So, again, with learning, how many people have really changed their practice, changed what they do? Maybe you could look at how many serious untoward events have happened. Say we've had teaching or education on diabetes, how many diabetic related avoidable events have happened since that teaching? But again, it's too complicated because there are so many factors that come into it that you can't readily correlate one with the other. (Responsible Officer, NHS Acute Trust, South, England)

> Obviously, people are participating in appraisals and the discussion could be in the appraisals and the plan in terms of their professional development. How do

> you measure that as an organisation? I think it is pretty challenging really. (Responsible Officer, NHS Acute Trust, Midlands, England)

One academic suggested that there needed to be more focus on the outcomes of lifelong learning rather than the process itself. They believed that employers should have an interest in achieving this as, ultimately, it would lead to improved practice.

4.9 The appraisal process

Given appraisal was cited as one of the only ways of measuring the effectiveness of lifelong learning, there was some discussion about the appraisal process itself. The general consensus was that appraisers needed to be able to challenge doctors' thinking around lifelong learning, if necessary. For example, by suggesting new areas to explore; asking doctors to consider what might be useful to them as an individual; as a team member; and as part of an organisation. Most hoped that this was being done but one or two of those interviewed suggested that more senior doctors might be more difficult to appraise, because appraisers could be intimidated by an appraisee at a senior level, with extensive experience. Several others raised the question of whether doctors needed to be appraised by someone within their specialty for the appraisal process to be most effective.

> So, again, it comes back to the conversation at appraisal, saying: What else could you do? What else might be useful to your organisation or your team? Where are the gaps? (Stakeholder 13)

> I interviewed somebody who was a Child Psychiatrist and she wanted to do this and that and the other for anorexia services in xx. Well, I don't know anything about child psychiatry, nor do I know anything about the organisation she's in, so I can't support their learning and development. (Academic 5)

5. Content and format of lifelong learning

Section summary

In addition to mandatory training, employing organisations were reported to offer an array of in-house learning opportunities from clinical updates and grand rounds through to lunchtime learning sessions.

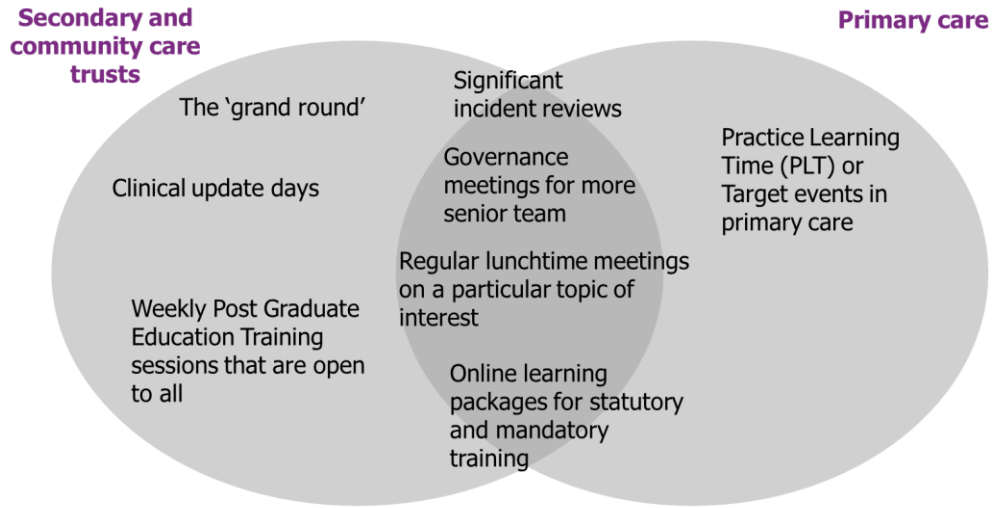
Whether learning was provided in-house or by external organisations, there were a number of points raised in relation to the content and format of lifelong learning:

- Individual doctors may focus on clinical skills early in their career and/or when learning time is 'squeezed'; whilst, later in their careers, they may display more eclectic tastes and a greater interest in leadership. It was thought that there may be an opportunity to promote leadership and management to doctors earlier in their careers.
- There was much value in everyday learning encounters, but a perception that doctors do not always have the confidence or means of recording this for appraisal and revalidation.
- Multi-disciplinary team (MDT) learning appears to be more established in primary care than secondary care. However, there is a general appetite for MDT learning as it is thought to help drive change.

5.1 In-house provision of learning opportunities

Employers provided numerous examples of in-house lifelong learning opportunities. These included but were not limited to those outlined in Figure 2:

Figure 2 - In-house learning opportunities



The content of these lifelong learning opportunities was reported to be driven by a number of factors:

- The need for organisational compliance (ensuring that staff are aware of latest guidelines/procedures).
- Interests and experience of specific individuals within the organisation.
- Quality improvement projects.
- Significant event analysis.
- Interesting and/or complex cases.
- Patient complaints/experiences.

Although lifelong learning was rarely evaluated for effectiveness at an overall level, a number of employers did report asking for feedback on their in-house courses/learning events.

There were no specific gaps identified in the in-house learning opportunities provided by employers. However, taking a broader perspective, two academics highlighted that the erosion of the medical family/team had been detrimental to less formal lifelong learning opportunities within employing organisations.

> I think one of the big problems that's reduced lifelong learning.....is that they [doctors] no longer feel part of a team that nurtures them, supports them, educates them, looks out for them…on rotas, so they're like ships in the night, picking up their tickets for the things that they've done but no one really looks out for them and says "you're in my medical family, I'll look after you, you're going to do this with me". (Academic 6)

> I didn't even know who my fellow consultants were any longer because we didn't have lunch together any longer and there's a huge amount of learning goes on over lunch…The erosion of the lunch hour, I think, has been one of the worst things for CPD and for patients. (Academic 5)

5.2 Preferences in terms of content/learning domains and topics

5.2.1 Individual doctors

Employers, stakeholders and academics raised several points in relation to the learning topics/domains preferred by individual doctors:

- As learning time is scarce, clinical skills may well be prioritised, as they are:
  - Vital to service delivery.
  - Key to doctors remaining secure in their scope of practice.
- Preferences often change as careers develop.
  - Early career doctors may be more focussed on clinical and educational work; those more established in their careers may display more eclectic interests or focus on specific areas, like leadership.

- Making the transition from learning directed by the training curriculum to more self-directed learning can be a difficult transition for some doctors to navigate.

5.2.2 Employing organisations

Undoubtedly, employing organisations were thought to value clinical skills; however, other learning domains were also high on the agenda as most of those interviewed pointed to how 'well-rounded' clinicians were important to an organisation.

> Traditionally training has concentrated very much on the clinical, and that's very necessary, but we do have to, at some point, face up to the fact that doctors are far more than just clinicians. (Director of Medical Education, NHS Acute Trust, South, England)

More specifically, some employers and stakeholders noted that when doctors made significant career transitions, for example to consultant or GP Partner, significant gaps in their management and leadership skills may be revealed, for example, they may lack understanding of organisational finances. Several suggested that training and lifelong learning opportunities should address these skills earlier in a doctor's career.

> I also think there is a gap in doctors recognising that, even from their very first job out of medical school, they are leaders and so some of the leadership and management stuff, I think, should come a lot earlier. (Stakeholder 6)

> We know all this stuff about consultants feeling very able to do the clinical job but not the managerial, not the teaching, not the leadership, not the financial stuff… It's about helping people understand that, actually, there are lots of ways that you develop, that you learn, and it's not just about clinical stuff. Some people need that legitimising and, again, some people have it delegitimised by the organisation in which they work. (Academic 4)

> Practice management, finances, those kind of things. There is absolutely no training for that either during medical school or after in your training years, nothing at all. (GP Partner, less than 5 salaried GPs, Wales)

Employers, stakeholders and academics further highlighted the increasing pressure that doctors were working under, even before the pandemic. Several suggested that there was an appetite within their own organisation and amongst doctors themselves to look at how lifelong learning could help doctors develop coping strategies and maintain their own mental health. One trust highlighted that there was potential to have CPD relating to mental health first aid and offering psychological support, whilst others simply spoke about a growing interest in wellbeing.

> Whereas traditionally going to a scientific meeting or a conference, or reading a journal, those kinds of things that are linked to a clinical practice have had CPD attached and therefore will probably take priority. But I think the vast majority of us would keep up-to-date with our skills anyway, so I think it's important for

> the other things to be supported as well. (NHS Acute Foundation Trust, South, England)
>
> In my experience, in the last five years with what's happened to the profession, by far the most valuable learning is around how to manage work-life balance. It's about how to look after yourself, it's about giving yourself permission not to be perfect and stopping beating yourself up. It's helping people with imposter syndrome, it's helping people to recognise what's proportionate and what's enough and it's reassuring people who are doing a really good job that they're doing a really good job in what is sometimes an undoable situation. (Stakeholder 6)

Other areas that were mentioned by employers as topics of learning that their organisation was interested in and/or encouraged were:

- Quality Improvement
    - Several employers and stakeholders explained that undertaking Quality Improvement projects pushed doctors outside of their comfort zone and forced them to think about what could be done better or differently – potentially improving practice. Quality Improvement was a particular focus for one trust currently in special measures.
- Increased emphasis on Equality, Diversity and Inclusion
    - At least one trust had put a focus on ED&I in the past 12-18 months and another suggested that it was a topic that required more attention.

> Being aware of the full context of your patients, the societal context. So, if you like, the societal justice angle. (Deputy Medical Director, NHS Acute Trust, North, England)
>
> I work in an area that is almost 97% white and that means that for us it's even more important to be aware of the effect of differential attainment. And for me, as the person that is responsible for our junior doctors whose proportion of non-white ethnicity is probably about 15%, it's vital that I try and understand what it must be like for those learners to come and work in my geographical area. (Director of Medical Education, NHS Acute Trust, South, England)

5.3 Format of lifelong learning

Ultimately, there was no one preferred format for learning as employers, stakeholders and academics all acknowledged that doctors would have individual learning styles and not all formats would appeal to all doctors.

> There is no evidence that one way of learning is any better than another, and particularly for people at this level, these are grown-ups. (Academic 1)

However, across the research the following formats of lifelong learning emerged as themes of interest:

Everyday experiences

Employers, academics and stakeholders all stressed the important role that informal learning encounters played within lifelong learning. The rapid literature review further supported the development of CPD and lifelong learning programmes that were grounded in the everyday workplace (see Appendix A within the appendices document). Individuals who took part in the research gave examples of casual 'corridor chats' with colleagues; seeking out colleagues for specific advice; responding to questions from trainees and; of course, patient consultations. All of these were thought to offer opportunity for doctors to reflect upon and learn from their own practice; however, it was believed that many doctors were less confident about including this less formal learning within the lifelong learning they recorded for appraisal and revalidation.

> I can't really think of a CPD course, a medical one, clinical one, that I've been on that has immediately impacted on my practice, as compared with me knocking on somebody's door and saying, "I don't know what to do now, what's my options?" (Academic 4)

> I might see a patient who has something that I'm not familiar with. I look at them, I interact with a colleague, the colleague who had more expertise says, "Ah, it's this and that"…….. You learn a bit about it and then maybe you go away and read a little bit about it, and now you think, brilliant, I now know what to do about that. Do you go away and think I'll record that somewhere? Probably not. (Associate Medical Director, NHS Acute Trust, South, England)

Peer to peer

Some employers reported encouraging peer to peer approaches within lifelong learning both within and across organisations:

- As a way of stimulating new ways of thinking/working (when the peer was from a different organisation).
  - This was perceived to be one of the key benefits of attending an external course.
- As a means of supporting doctors who might be more isolated in their professional role (this was particularly relevant to doctors working in small specialties and/or in rural areas).
- As a way of supporting doctors to make significant role transitions, for example, new consultants' forums.

> I'm trying to encourage people to network outside the organisation at all levels, and to get involved, because that stimulates learning." (Medical Director, NHS Acute Trust, North, England)

Multi-disciplinary team learning

Multi-disciplinary team learning was well established within general practice through the funding of Protected Learning Time (PLT). Those working as GPs believed the main benefits of multi-disciplinary team learning were:

- The ability to learn from different perspectives.
- The ability to bring about change (as the whole team is invested in the learning).

> To function properly as a team, you do need to do your training together…... It's of far greater benefit to patients because everybody sings from the same hymn sheet. (Stakeholder 12)

> Everybody; the paramedic, the desk practitioners, the practice nurses, the doctors, the salaried doctors, the pharmacist if it's applicable, the whole MDT come to our education events and bring different viewpoints, and it's really, really valuable to learn together because actually we look after people together. (Stakeholder 6)

Employers within secondary and community care were also keen to encourage a multi-disciplinary team approach to learning, however, some explained that it could be challenging to deliver.

- Different professions have different mandated learning requirements.
- Old and established hierarchies may act as barrier to joint learning.
- Different professions can be on different contracts, with only doctors having learning time built into their job plans.

> There still is a perceived divide, a perceived hierarchy by some, in terms of doctors need this; advanced practitioners need that; and nurses need that. There is a bit of resistance in terms of how we can learn together….We're trying to do a lot more multi-professional learning in terms of things like simulation, in terms of deteriorating patients, in terms of human factors. We're trying to break down those hierarchal barriers by … getting people used to being in those situations with each other. (Director of Medical, Education, NHS Acute Trust, South, England)

The rapid literature review also indicated that there was support for the development of CPD and lifelong learning programmes that are team-based (see Appendix A within the appendices document).

Online learning

Online learning was a popular format for lifelong learning, traditionally associated with the delivery of mandatory training but, as a consequence of the pandemic, now a vehicle for a much wider array of learning (see section 8.1). There was also a burgeoning interest in short podcasts given 'bite-sized' learning was thought to fit well with doctors' busy lifestyles.

Simulation

Finally, several employers and stakeholders spoke of a growing interest in simulation within trusts and it being used for doctors at all levels.

> There are fantastic actors who know exactly the answer to all the questions and you can get a really good history. You can really train people and test people with a good simulation. (Responsible Officer, NHS Acute Trust, South, England)

> We've done simulation training as well ourselves in the trust, but we are also thinking about collaborating with our university colleagues who are doing undergraduate simulation. (HSC Trust, Northern Ireland)

5.4 Examples of different approaches to lifelong learning

The following examples give more details about how different settings approach lifelong learning for doctors. Amongst other things, the examples help to highlight:

- The variety of in-house training opportunities provided by employing organisations.
- The focus that employing organisations place on mandatory training.
- The perception that lifelong learning is the responsibility of individual doctors.
- How service demand impacts on the time available for lifelong learning.
- Potential issues with an individually allocated study budget.

Example 1 – Large Acute Trust /Health Board

The permanent staff, permanent SAS and consultant body must have completed – we call it a passport. So the passport would include all of the mandatory projects and must be completed by the doctors

The permanent staff, so that would be SAS and consultants, CPD again primarily it is with the doctor themselves. And then the line of responsibility, it really flows up through into appraisal and the appraiser to ensure that the doctor is keeping up-to-date with the requirements.

So there is a degree of responsibility which is the individual's responsibility to ensure that they're current and up-to-date, but also the organisation provides each doctor with funding to ensure that they can go on courses or conferences to ensure that they are up-to-date. The organisation also commissions education extra money to be pooled into the organisation and provided to staff and has also – is now producing its own courses to ensure that permanent staff understand and gain knowledge and experience of those areas that constitute a doctor but were never trained on really. So, for example, litigation, how to manage an unruly member of staff, complaints management, and their own wellbeing, how to stay sane.

In terms of how do we know what to teach? You know, you can't just expect individuals to run – to understand the full complexities of healthcare. So we would also use complaints, IR1s, serious incidents, coronial cases, judgments, so we would take those and push those down through the educational fellows and then they spread it out through Zoom. So there is access to all these other different patches, if you like, that are required to really make a very mature doctor. And then, on top of that, we would also use those scenarios where things have gone badly wrong or happen frequently, we would bring them in to the simulation. So we simulate it all over again and enable people to see the disasters that have happened historically.

The other thing that I brought in was the relatives of patients when things go wrong. So they are also able to give voice and to describe what happens when it goes wrong. I actually pull the relatives when it's still quite fresh, when the death was fresh.

Example 2 – Private Provider

As a company we provide quite a lot of internal courses…doctors are assigned modules to do that are relevant to what they do and the safety of what they do, so things like intermediate life support, basic life support, safeguarding. You know, there is a whole bunch of these modules that you do online each year…….So that's the internal learning and I know that because I'm RO I see everyone's appraisal, so I know that they include that as part of their lifelong learning.

So if you do it properly – I mean you only need to log in once a month, look at what's been allocated, because it comes in in drips. "This month you'll be allocated three modules. You've got a month to complete them." So it's not like a pressured flow but you need to keep up-to-date with it. And, as an organisation, you can then evidence that everyone is getting their yearly safeguarding training, they are getting their infection control training. You know? And if they don't do that then they can't successfully apply for funding. So there is a sort of balance to it. Yes, you can go externally to this expensive course but have you done the good quality stuff that we have internally?

And then there is a budget……I'm often asked "What's the CPD position?" I usually say, "We have a central pool of money, not individually allocated." The problem with individually allocated – I'll tell you what the problem is with that. You get doctors who don't spend it. So any money in a budget that is not spent gets reviewed and you tend to lose it then in the next budget. So by holding it centrally you get much more control over what it's being allocated to rather than just throwing the money at the doctor and then saying, "Here is your CPD money."

Example 3 – General Practice

You're responsible for your own lifelong learning. And in terms of the mandatory stuff you might get the managers coming and asking you to do it. In general practice you might have your practice manager encouraging you to do the fire training or the communication training or whatever . But even things like safeguarding or cervical smear training, which is mandatory if you're going to continue doing cervical smears, those kinds of things are your responsibility. You need to keep tabs of where you're up to with them and renew them as and when needed.

We would have practice learning days, PLT days. So these are half days, half a session in a month/month and a half, that in the pre-COVID times we would have to organise our own CPD. So every four weeks or so the practice would shut down for the afternoon and we would organise our own CPD for that session. So depending on what the majority of doctors need/want, we would organise either speakers or, you know, to do a lecture or a new service that is going to be organised for them to come and speak to us about it.

We had the half days and then we do what we wanted individually based on our needs. There is no time in your working day to do it. From the time you get into the practice to the time you come out of the practice it's a full day, non-stop, and generally we don't get admin time or any other time built into our schedule for us to sit down and do any learning. So it's difficult on a working day, whatever has to be done usually has to be taken as a study leave I suppose. If you're going on a proper course, then you take it as a study leave and then it's more protected.

I don't think there is much direction, unless you yourself want to……for instance, we have got a diabetes desk which is available and, as a part of that diabetes desk you could also become an insulin prescriber and manage insulin care. And as a practice at the moment we don't have that particular skillset. We don't have a doctor who is confident in doing that. So if we felt as a practice that we wanted to offer that in the future to our patients we could potentially train ourselves up.

6. Barriers to lifelong learning

Section summary

There were thought to be a number of barriers to lifelong learning associated with individual doctors (attitude to learning, life-stage, working part-time, language); specific roles (SAS, LED, locums, self-employed doctors in the private sector) and organisations (service demands, specialty, culture, location, funding, facilities). However, the overarching barrier to doctors engaging with lifelong learning was perceived to be lack of time, in large part driven by service demands.

Stakeholders, academics and employers identified a number of barriers to lifelong learning. Time or, lack of it, was without doubt the most talked about; however, there were numerous other barriers to lifelong learning which can be broadly viewed as occurring at an individual level, role level or organisational level:

6.1 At an individual level

Attitude to learning

Whilst, doctors, as a profession, were generally believed to be intrinsically motivated to learn, it was thought that some were more motivated to engage in lifelong learning than others. Several employers, stakeholders and academics also highlighted that working under pressure and the threat of burnout potentially erodes positive attitudes to learning.

Life-stage

Employers, stakeholders and academics all recognised that life-stage could be a barrier to undertaking CPD. In particular, there were several mentions of:

- The challenges facing doctors with young families (both in finding the time, and potentially funds, for lifelong learning).
- The negative perception of lifelong learning amongst some doctors approaching retirement.

Working part-time

Several employers, stakeholders and academics highlighted the difficulties experienced by part-time doctors in relation to lifelong learning. The general perception was that part-time doctors needed to undertake the same amount of CPD as their full-time colleagues, yet their practice and time to undertake lifelong learning was likely to be more limited.

> It's the same for people that work less than full-time, they're expected to demonstrate this same level of learning. I'm not suggesting it should be

> mathematically translatable, but there needs to be some recognition about your capacity and what your scope of practice is and the level of expertise required you have to demonstrate. (Stakeholder 9)

Language

The issue of language was raised by one or two employers. They pointed out that lifelong learning opportunities were generally in English and that identifying, undertaking and recording lifelong learning could be challenging for doctors who did not speak English as a first language.

> Locally employed doctors can struggle because a lot of them are from overseas, they may be new to the country, they don't realise what they can record, where the opportunities are, it often takes them a bit more time to get up to speed. (Associate Medical Director, NHS Acute Trust, South, England).

6.2 At a role level

LEDs and SAS doctors

The contracts for LEDs were reported to vary across trusts. It was believed that SAS doctors were treated somewhat better; however, a number of employers suggested that both these groups of doctors faced cultural (organisational) as well as practical barriers to lifelong learning.

> But the locally employed doctors, because we give them less allocated time, depending on their personal motivation and who their educational supervisor might be, they do or don't get the encouragement to think broadly and capture their learning. (Associate Medical Director, NHS Acute Trust, South, England)

Locums

Several employers, stakeholders and academics highlighted that being a locum was a barrier to lifelong learning, more so for agency locums who:

- Are unlikely to have study time built into contracts.
- Are likely to suffer loss of earnings when taking time out for study.
- Have a perceived lack of professional networks (which may impact on informal learning opportunities).
- (If working in general practice) may not undertake specialist roles and therefore have no incentive to upskill in a particular area such as diabetes, sexual health (as a number of salaried GPs and GP Partners did).
- May be excluded from in-house learning opportunities.
  - On a practical level, employers pointed out that agency locums would not have access to any internal systems used to promote lifelong learning opportunities, such as lunch time sessions.
  - On a more emotional level, there was a sense amongst employers that locums had actively chosen their career path and that they should not necessarily enjoy the benefits that permanent members of staff did.

> They're completely self-funded and if they don't work, they don't get paid. If you're in a trust you're paid while you're learning. If you're a locum you don't get paid……. Add to that the fact that you may be excluded from learning opportunities within a trust because you're there to fill a service need. (Responsible Officer, Locum Agency, England)

Self-employed doctors in the independent sector

Several stakeholders highlighted doctors who were self-employed working in the independent sector as potentially vulnerable in terms of lifelong learning. Unlike many of their NHS counterparts, they were not thought to receive funding and study leave for lifelong learning.

> People working in private healthcare, for the majority of their time they won't be allowed any CPD as part of their contract because obviously they're self-employed. Often any spare time they do have is probably for doing a little bit of NHS work. I think, again, they're not perhaps making the space because they're not earning anything doing CPD…. Those are the people, I would say, who are almost at risk of not being able achieve it or might find it more difficult. (Stakeholder 13)

6.3 At an organisational level

Service demands

Employers, academics and stakeholders universally believed that service was prioritised over lifelong learning in both primary, secondary and community care. They explained that lifelong learning was often the 'first thing to go' (with study leave declined and SPA time eroded by other demands) forcing doctors to undertake lifelong learning in their own time. Some envisaged that this would continue, and worsen, as a result of the pandemic.

Several employers further linked service demand to issues with recruitment and retention and explained how gaps in rotas made it difficult to release some doctors for study.

> We've had difficulty recruiting, people aren't available, there are gaps in rotas all the time at all levels. We have suffered greatly as a consequence of that. So you are putting service first and everything else has to take a back step. (NHS Health Board, Scotland)

Specialty

Some specialties were thought to face more challenging service demands than others, for example, Emergency Medicine; making it more difficult to find the time for lifelong learning.

> I think there are certain specialties where they do have a struggle. For example, I think Accident & Emergency is one specialty where they do – I think it's mainly to do with [doctors'] availability rather than access to CPD….. I don't think it's an individual doctor problem; it's much more to do with the specialties. (Appraisal Lead, NHS Acute Trust, North, England)

One stakeholder believed that working in a District General Hospital where breadth of practice was deemed to be more challenging could also result in some specialties facing particularly challenging CPD requirements. For example, an anaesthetist in a District and General Hospital was required to work across maternity wards, paediatrics and emergency medicine, and needed to be confident in a broad scope of practice (compared to an anaesthetist working in a subspecialty of orthopaedic surgery).

Culture

Organisational culture was identified as a potential barrier as well as an enabler of lifelong learning. Several issues pertaining to organisational culture were identified:

- Employing organisations could be resistant to change, preventing doctors from implementing new ideas that have come about through lifelong learning, thus diminishing the appetite for learning. In part, an MDT approach to lifelong learning was welcomed in primary care, because it was thought to address this barrier by ensuring the wider team was bought into any changes.

  > I think the system is so hierarchical and so dense that, when colleagues go to try and make a difference in their clinical area, it's so hard to do that, that they get fed up. (Stakeholder 8)

- The existence of hierarchies and/or peer pressure whereby more junior doctors are denied or are unwilling to put themselves forward for certain opportunities.

  > Within a department there is often a sense of a hierarchy whereby the professor and a particular physician or surgeon will want to go, which means that everybody else doesn't [get the opportunity]. Now the good departments recognise that and they'll rotate it every year. But … that may be where you see an unfairness or inequity. I think we have to be open about it – I would worry that perhaps culturally there are some influences. (Medical Director, NHS Acute Trust, South, England)

- Lack of involvement in training junior doctors (e.g. not a training practice or teaching hospital) potentially resulting in a less open learning environment.

Funding

Funding was not generally highlighted as a barrier as employers, stakeholders and academics recognised that doctors often plugged any gaps by funding lifelong learning themselves; however, there was concern that doctors may be less willing to fund their own lifelong long learning in the future (due to increased student debt; partners on furlough; salary stagnation etc.) This may place increased pressure on organisations to fund lifelong learning and there were concerns that it may be more of a barrier in the future.

Location

Several employers in rural areas referred to their location as a barrier to lifelong learning. They explained that travel to a central location to attend courses, conferences or even team meetings could have significant time implications. Location was also perceived as a barrier by employers based in the devolved nations as they highlighted travel and time costs when events were based in England.

Space/facilities/infrastructure

There was one mention by an academic that the lack of space/learning facilities within organisations was also a potential barrier to lifelong learning and that Private Finance Initiatives hospitals, especially, did not have sufficient learning and development space.

Finally, one or two employers within the NHS highlighted frustrations about not being able to access some online learning opportunities at work because of the organisations' IT infrastructure, for example, a firewall blocking YouTube videos.

7.A systemic view

Section summary

The current approach to lifelong learning was appreciated for allowing doctors to determine the direction of their own learning (albeit influenced and/or supported by other players, including appraisers as well as external organisations, such as the Medical Royal Colleges and the GMC). However, there were also several potential issues associated with the current system:

- Dominance of CPD points and lack of clarity about the role they play in appraisal and revalidation.
- Recording of lifelong learning (in particular duplicate recording and the perception that everyday learning opportunities were more difficult to record).
- Reliance on the appraiser-appraisee relationship to help direct and evaluate lifelong learning.
- A lack of certainty that current approaches to lifelong learning are addressing future needs.

7.1 Main positives associated with current approaches

Two main positives associated with the current approach to lifelong learning emerged from interviews:

- Doctors are trusted to identify and pursue their own learning needs and interests, rather than the type and content of lifelong learning being mandated at a national level.
  - Whilst most saw this as positive, there were several employers and stakeholders who were less convinced (see section 7.2).
- The appraisal system has the potential to reach all doctors, including those who may traditionally have been less well supported, for example, locums, LEDs, single handed and/or self-employed GPs, doctors who were less intrinsically motivated to learn.

> My personal feeling is that locums and SAS doctors will always be more vulnerable. At least we have something that reaches them once a year where, if the appraisers are well trained and supported enough, they can empower the individuals to get more support. (Stakeholder 6)

> There is no employer who's overseeing GPs to that extent and able to say 'well, hang on a minute, you haven't actually kept yourself up to date in this particular area'. So, I think in that regard the revalidation process is the key, for someone

> independently to be evaluating each of those doctors on a five-yearly basis (Academic 2)

7.2 Potential issues with the current system

Dominance of CPD points

One of the most talked about issues within the current system of lifelong learning was the importance that the Medical Royal Colleges placed on CPD points and how this has driven perceptions of CPD as a 'tick box' exercise. Even though all stakeholders and academics, along with most employers, recognised that the GMC did not require CPD points for appraisal and revalidation, there was still an element of confusion amongst a minority of employers and a call for greater clarity across the board.

> The GMC say "you have to do enough to keep up to date at what you do, tell us what you do and then tell us what you do to keep up to date for that and why it's enough…", and I think that speaks to professionalism, it speaks to trust in doctors wanting to do a good job. It's a really powerful, empowering message which we have then completely undermined by saying "and do it by telling us what 50 things you've done." (Stakeholder 6)

One or two of those who took part in the research highlighted that several Medical Royal Colleges had moved, or were moving, away from a points-based system, for example the Royal College of Paediatrics and Child Health (RCPCH), as shown below.

Major elements of the **Royal College of Paediatricians and Child Health's CPD scheme taken from the RCPCH website**[4]

- A reduced focus on CPD credits - they are no longer a requirement, and set limits on CPD credits for key activities have been removed
- Large emphasis on flexibility, balance and self-accreditation – any activity that you learn from can be recorded as CPD
- Expectation that doctors should reflect on their learning, in line with GMC requirements
- Simple CPD categories of non clinical and clinical (subdivided into internal, external and personal CPD)

The elements underpin RCPCH recognition of the value of learning from a range of different activities, whether formal courses or ad hoc activities of relevance to practice.

Much learning occurs outside formal courses and conferences. Doctors should be able to self-accredit this learning.

In addition, while acquisition of CPD credits provides a useful steer for many doctors, the important focus needs to be on what has been learnt and its effect on practice. Thus, collection of CPD credits is no longer required, but recommendations are made for those who prefer to continue recording them.

[4] CPD scheme and guidance for paediatricians | RCPCH

However, it was also pointed out that Medical Royal Colleges, employing organisations and the GMC had different goals with lifelong learning that could require different approaches. The Medical Royal Colleges focus on the development of the individual 'professional' as opposed to the development of an employee or a team, and the GMC was often thought to be more intent on identifying doctors whose performance was not meeting professional standards.

> A Medical Royal College is interested in the profession, the content of the profession, guiding people through their particular specialty and sub-specialty. ….. they don't see it as an employer would see it. An employer sees it completely differently. An employer, a trust …. has a much more instrumental approach to this, they just see doctors as a set of skills that can be moved around, that you have to pay for, that can run different sorts of clinics. Sometimes the GMC with its transferability and flexibility buy into that employer's agenda, probably because that's a Government agenda, it's not a professional agenda as such. (Academic 2)

Recording lifelong learning

Recording of lifelong learning was variable across the four nations, with Wales (through MARS) and Scotland (through TURAS) appearing to operate more centralised systems than England and Northern Ireland. In England and Northern Ireland, the recording of lifelong learning appeared more varied. There were reports that mandatory training was logged on in-house recording systems (e.g. Electronic Staff Records) and that broader lifelong learning was noted on mobile apps and/or inputted into Medical Royal College e-portfolios or, in primary care, software such as Clarity and Fourteenfish. The result was that evidence of lifelong learning could be stored on several systems, duplicating time and effort.

> A lot of the Occupational Health doctors would be using the Faculty of Occupational Health's site to upload all their CPD and then they would come to their appraisal and just reference it, but you would see nothing of it. So, you would then have to go back and say: "you need to download me a sample of it to put into this". It's almost like it's in two places and I think it would be neater just to have it in one place, just either in the appraisal or somewhere else. (Stakeholder 14)

Several employers, stakeholders and academics also believed that current methods of recording lifelong learning may not be able to sufficiently capture everyday experiences/learning encounters.

Reliance on appraiser-appraisee relationship

Most employers, stakeholders and academics recognised the importance of the appraiser-appraisee relationship in directing lifelong learning. They also highlighted that experiences of appraisal could be mixed (see section 4.9).

> I think that we have a good appraisal process in Wales, I think it's well administered, it's well supported by IT but it needs commitment from the appraisees and the appraisers to work well and there are many a slip [instances where this does not happen]. (Stakeholder 3)

Focus is on individual doctors (not their role within the team)

Several employers and stakeholders noted that the appraisal process asked for feedback from patients and colleagues, but that it could do more to look at the role that individual doctors played within a team.

> I think that the value of feedback about your performance as a team is huge and currently that is a gap on what we're asked to reflect on in our appraisal. I think there is something about recognising that our role in the team is a really important thing to think about. (Stakeholder 6)

Learning may not be addressing future needs

It is difficult to assess how well the current approach to lifelong learning is addressing future needs. However, the research indicates:

- There is a lack of strategic direction for lifelong learning provided at an organisational level.
- Instead, individual doctors self-direct their own learning and rely on the appraisal process to highlight learning needs.
- There are variable organisational processes in place to ensure that all non-training grade doctors have the time and funds available to undertake lifelong learning.
- There are some perceived gaps in doctors' management and leadership skills.

> When it comes to the lifelong learning of a doctor, who decides? I can see one point of view which is "I'm the doctor, I'll decide because I know where I want to take my career", but most doctors are employed by the public purse and work in the NHS. So, should it be the Medical Director of the employing body who decides what you will do for your lifelong learning? Because it's the Medical Director that knows what skills he needs you to have, whether you like it or not. (Stakeholder 10)

> We do very much use the GMC's Duties of a Doctor as a template for what we expect. And I think it does set out what individual doctors need to do… but, given that the vast majority of doctors who are registered with the GMC are accessing NHS money to fund their lifelong learning, I think it might be sensible for there to be some recognition of the greater need…. the fact that it's not all

down to you as the individual doctor, but rather that you do sit within an organisation who sits within the national structure. (Director of Medical Education, NHS Acute Trust, South, England)

8. COVID-19 impacts

Section summary

COVID-19 has impacted both positively and negatively on lifelong learning for doctors. Perceived positives were:

- Increased access to online learning opportunities.
- Facilitation of team-working.
- Greater opportunity to reflect on everyday learning opportunities.

The perceived negatives were:

- Lack of time to undertake CPD.
- The dominance of COVID related learning.
- Limited clinical opportunities.
- Lack of informal and formal networking opportunities.

8.1 Perceived positives of COVID-19

For the most part, COVID-19 was thought to have instigated positive changes to lifelong learning.

Increased access to online learning opportunities

By far the greatest impact of the pandemic on lifelong learning was thought to be increased access to online learning opportunities. As a result, some employers and stakeholders reported that the amount of CPD that doctors had undertaken was not necessarily diminished by the pandemic.

Employers, stakeholders and academics recognised that this move to online (whether it be video conferencing or online learning modules) has had a number of benefits:

- Reduced the need to travel and saved time.
- Allowed more doctors to participate, including locums and self-employed doctors who may have traditionally struggled to attend face-to-face sessions.
  - Overcome venue capacity issues.
  - Allowed doctors to watch a recording of an event.
- Potentially opened the door to more MDT learning in secondary care.

> So that now with virtual learning, evening courses, weekend sessions, I think has made it easier for them to learn. (Stakeholder 14)

However, some employers raised the question as to whether the move online had irrevocably changed the landscape of lifelong learning.

- Would it be more acceptable in the future to conduct meetings out of hours and thus negatively impact on work life balance?
- Would the value of face-to-face conferences be diminished in the eyes of employers and what will that mean for networking opportunities?

> It's all been very different the last 18 months … and that might be interesting going forward. With the big conferences that specialties tend to have where you'll get large numbers of a department going, I think the risk now is that if you're a medical manager you say, "I don't want 16 of you going to that. What's the point? It's all online, three of you can go, the rest of you can watch it in your SPA time, on video." I suppose the climate or the landscape of CPD may change. (Medical Director, NHS Acute Trust, South, England)

Facilitation of team working

Several employers and stakeholders shared examples of how the pandemic had broken down hierarchies, brought teams together and resulted in better communication between primary and secondary care – in part due to the ease and greater acceptability of online meetings.

> The pandemic definitely had unintended good consequences …. It did promote better team working during the worst of it. Actually, we noticed that…. definitely better team working, took away hierarchies, broke down barriers…there was a real pulling together. (Stakeholder 11)

Greater opportunity to reflect on the everyday opportunities

Some employers, stakeholders and academics spoke of the positive changes to the appraisal and revalidation process and how they had allowed doctors greater opportunity to reflect on everyday learning opportunities, as more tried and trusted CPD opportunities may not have been available to them. They believed there was an opportunity for the system to maintain this focus.

> In some ways the interesting thing is they [GMC] are more keen on you reflecting on your learning and embedding your learning rather than just demonstrating you've attended it. I think that's been very welcomed by the profession and the move away from 'you must demonstrate this number of hours' has, I think, been broadly welcomed and depressurised it. (Stakeholder 9)

> One of the few things that was positive was that the attitude was more 'do you feel you're keeping on top of your learning? Can you give us some examples of what you've done? Can you tell us why you thought that was relevant?' It was more formative than it was summative. And I think that for the majority of us who have always far exceeded the number of points, if we actually bothered to count them, that's more useful. (GP Partner, less than 5 salaried GPs, Scotland)

One or two stakeholders highlighted additional positives:

- Doctors demonstrated that they had more transferable skills than previously thought.
- It had helped push through the agenda for, and investment in, simulation.

> The pandemic forced everyone to become a generalist again and they suddenly remembered that was alright, that they could do that really quite well. We had neurologists, who normally wouldn't go near an acutely unwell patient for love nor money, looking after people on the respiratory ward with COVID. They actually remembered how to count the respiratory rate and monitor oxygen levels and track patients' deterioration or improvement and prescribe drugs. A lot of these are generic skills…. the fact you apply it to someone's neurological condition, or their respiratory status, is almost incidental…. There's not the insurmountable gulf that people supposed there would be. (Stakeholder 9)

8.2 Perceived negatives of COVID-19

Whilst the pandemic has had significant positive impacts on lifelong learning, there were also several negatives put forward:

Lack of time for CPD

Doctors, employers and stakeholders pointed out that service demands, particularly high in some services, had impacted negatively on the time available for doctors to undertake lifelong learning.

> I think COVID hasn't helped. It's not just intensive care, it's actually throughout general medicine, we've had loads of doctors doing extra work and, of course, they've got behind on lifelong learning and CPD. (Medical Director, NHS Acute Trust, North, England)

Many were concerned that that the lack of time for CPD would be a continuing trend as services attempted to catch up on the backlog of cases resulting from the pandemic.

> Come next spring, when things are sort of back to normal, you've got a workforce that is faced with two–three years of backlog and it's going to be really difficult for people to get time, because the pressure will all be on doing extra work. (Medical Director, NHS Acute Trust, South, England)

The dominance of COVID related learning

Some reported that much of the lifelong learning taking place within the pandemic was focussed on understanding COVID-19 as well as the associated protocols around infection control etc. and less attention had been placed on other topics of importance.

> I think locally a lot of the training has fallen apart. It was so COVID-focused and we trained well for COVID, but beyond that it's fizzled out a little bit and we're trying to rebuild it. (Deputy Medical Director, NHS Acute Trust, North, England)

Reduction of PLT in primary care

There were several reports by GP Partners PLT sessions going 'by the wayside' during the pandemic and a lack of certainty as to when they will return. However, this does not appear to be the case across the board, with one GP Partner reporting an increase in funding for PLT.

> That's all gone in the last 18 months and we don't know for definite when, or if, that is going to return. (GP Partner, less than 5 salaried GPs, South, England)

Limited clinical opportunities

Several employers and stakeholders expressed concern about the limited clinical experience that some doctors had had during the past 18 months. This was thought to be a particular issue for doctors in critical training grades and some self-employed doctors working for private providers. It was suggested that these doctors may need to regain confidence.

> Clinical experience was really a big disadvantage, particularly for those in critical progression roles. Imagine if you're a trainee surgeon and you only have a year to go and you don't get to take out an appendix for the last six months. (Stakeholder 11)

Lack of formal and informal networking opportunities

Whilst all employers, stakeholders and academics identified that lifelong learning had successfully transitioned to online formats, most recognised that meeting online did not provide the same networking opportunities as meeting face-to-face. Whether that be chatting to existing colleagues after in-house meetings or meeting peers at conferences.

> You do miss the networking aspect of it … I always come away from conferences with not just what I've learnt in the lectures but also what I've picked up from the people I talk to. (Responsible Officer, NHS Acute Trust, North, England)

9. Looking to the future

Section summary

There was little appetite amongst employers, stakeholders and academics for the GMC to extend its role in terms of in lifelong learning, and some were nervous about any changes in approach from the GMC. That said, there were several suggestions made:

In relation to guidance:

- Placing greater emphasis on everyday learning opportunities.
- Outlining good practice for mandatory training.
- Emphasising team working.
- Potentially offering more guidance for appraisers/appraisal leads.
- Potentially offering more guidance around reflection.

In relation to influencing the direction of, and messaging around, lifelong learning, there were suggestions that the GMC should:

- Work with other organisations to communicate a consistent message around lifelong learning.
- Shout about the importance of lifelong learning - for all doctors - to help ensure learning time is given and not compromised.
- Ensure the right tone around lifelong learning, this could include addressing doctors' concerns/fears around reflection and building on the changes to the appraisal process brought in as a result of the pandemic.

Finally, a minority of those interviewed put forward suggestions that would involve a more 'hands on' approach from the GMC, such as holding trusts to account for lifelong learning of doctors not in training programmes and re-licencing exams.

9.1 Understanding the context for change

A number of employers and stakeholders (rather than academics) questioned why the GMC was undertaking research into lifelong learning and CPD, with one or two specifically asking for the existing issues to be evidenced. This suggests that any change to the current system would be better accepted if the drivers for change were communicated.

Whilst there were questions about the need for change, employers, stakeholders and academics put forward a number of suggestions for the GMC to consider going forward.

9.2 Suggested actions for the GMC to consider

9.2.1 Guidance

For the most part employers, academics and stakeholders believed that the GMC should 'stick with guidance' and they were concerned about the GMC stepping beyond this. For those that did suggest that the GMC could provide more guidance, the following areas were identified:

Greater emphasis on everyday learning opportunities

Throughout discussions employers, stakeholders and academics talked of how day to day practice presented learning opportunities. Going forward, some wanted greater recognition of everyday learning opportunities within the guidance as well as how this less formal learning could best be recorded.

> I guess it would be to champion the informal and to get people to really recognise how much they learn from just doing the job. (Academic 4)

> I think it would be good to hear more discussion – more recognition of the fact that learning is intrinsic in what we do, and more discussion of the fact that reflection, quality of learning, evidence of development in practice, is just as valuable as a certificate or a list of the podcasts you've listened to. (GP Partner, less than 5 salaried GPs, Scotland)

Outline good practice for mandatory training

Guidance on best practice for mandatory training was of interest to some employers and stakeholders. They believed this would help promote the importance of mandatory training to all doctors and set a national standard. However, several others expressed concern that moving towards mandating any element of lifelong learning at a national level could potentially increase resistance amongst doctors and would have cost implications for employing organisations.

> What I do think could probably be improved, similar to the way that we as an organisation say to our doctors, "We have an expectation that you will do a safeguarding module, this module and this module." There is nothing nationally that does that. So, it is down to a doctor to identify what they want to do as part of their CPD and the doctor, in theory, takes it to a peer group and the peer group have to agree that this is a good package of learning. I think that system generally works well, but I wonder if there are some things that we should be a bit more formal about. (Medical Director, Private Provider, England)

Emphasise team working

The importance of teamwork was referenced throughout the research. Several employers and stakeholders called for the GMC guidance to place greater emphasis on individual doctors demonstrating how they worked within a team.

> It's how you can emphasise team working and get people to provide evidence of how they're working in teams. There are things like colleague feedback and so forth but more team descriptions, how they're working in a team, what is their team understanding, more emphasis on that. I think that's very, very important. (HSC Trust, Northern Ireland)

More guidance for appraisers/appraisal leads

The appraisal process was generally regarded as the main method of evaluating the effectiveness of lifelong learning, yet some employers and stakeholders questioned if all appraisals were carried out to the same standard, suggesting that there was scope to offer more guidance to appraisers and appraisal leads, with one or two calling for Quality Assurance of the appraisal process.

> I think quality assurance of appraisal is key because you don't accept the input forms if they're not filled out correctly, you don't sign them off if there is no evidence of reflection. That's where the Responsible Officer and people within the appraisal office can help, which is giving people the support to say, "These are the standards that we expect and if they're not met then we don't accept the forms." (Medical Director, NHS Acute Trust, South, England)

More guidance on reflection (or communication of existing guidance)

There was some discussion of how well doctors understood reflection and how easy they found it to write up their reflections. It was noted that some doctors wrote detailed essays (making the process potentially onerous) and others recorded very little. This led several employers, stakeholders and academics to suggest there could be more guidance around reflection specifically.

> What I do find is that the people who really are good at showing what they've learnt from a course and reflecting are usually the younger doctors because they've had to reflect through their training more recently, whereas this idea of documenting a reflection is something that some doctors find really difficult. I think it's not that they can't do it, I think doctors are always reflecting, it's just documenting it - some resist and some just simply don't know how to. (Stakeholder 14)

Offer reassurance around reflection

As part of this guidance, some doctors and stakeholders felt there was a need to recognise and address the impact that the Bawa Garba case has had on how doctors feel towards reflection.

> It almost feels like reflection has become a little bit unsafe. I think there's quite a bit of work to do to make it safe again. (Stakeholder 13)

> Looking into a lot of the appraisals, it's very clear that the doctors, while they've done a reflective piece, it's clear when they are writing that they have concerns that the GMC will behave as it did as an organisation with the previous paediatric

> case and turn its back on the doctors and enable doctors to be pursued and criminalised because of their inadequacies. There is a lot of anger, an awful lot of anger. (HSC Trust, Northern Ireland)

9.2.2 Influence and communication

There was also a call from some quarters for the GMC to use its power to influence the general discourse around lifelong learning and CPD, focussing on both the tone and the content of the message.

Work with other organisations to communicate a consistent message around lifelong learning

Several employers, stakeholders and academics were keen to point out that the GMC should work with other key players (healthcare regulators, Medical Royal Colleges) to bring about changes to lifelong learning, they highlighted:

- The importance of acknowledging that doctors do not work in isolation, they are part of a wider healthcare team that do not all have the same regulatory requirements.

> Unless there's a multi-professional regulator approach to this, there's no point in going back and trying to do something useful at base that requires the involvement of your nursing colleagues and your physio colleagues and two or three other professional groups, unless their regulators are also encouraging them or requiring them to move in a similar direction. It's not to say that everybody has to have the same regulatory requirements, but it does require the regulators to work more effectively together. (Academic 2)

- Within the medical profession there is still confusion in relation to the requirements of the Medical Royal Colleges and the requirements of appraisal and revalidation. Many would welcome greater clarity.

> I think the College requirements are not what the GMC state and again they are different from what the employer says. You've got these three different areas and the bottom line is the GMC trumps them all because that's what doctors need for their licence, but doctors then possibly go overboard which is perhaps why CPD in some cases fills people with more horror than it needs to. (Stakeholder 14)

Shout about the importance of lifelong learning - for all doctors

Almost all employers, stakeholders and academics recognised that service delivery was prioritised over lifelong learning. Many highlighted that the pandemic had further compounded this issue. This led to some suggesting that the GMC could play a vital role in promoting the importance of lifelong learning and protecting time – for all doctors.

> I think strong words from national bodies are always useful because, particularly as we go forward, there is a huge amount of work that needs to be done to deal with the backlog of patients, so there is going to be a bit of tension between the needs of the service and other things like education, CPD. (Responsible Officer, NHS Acute Trust, Midlands, England)

> It would be jolly handy if the GMC, or somebody, said, "It is compulsory for all locally employed doctors to have X, Y and Z", because it would make it easier for me as somebody who has a role in trying to make sure doctors get the right opportunities. (Associate Medical Director, NHS Acute Trust, South, England)

Establish the right tone

There were several mentions of how important it was for the GMC to set the right tone in its communication of lifelong learning. One or two employers highlighted that the recent changes to the appraisal system (verbal reflections, the inclusion of a wellbeing question) were helping to do this.

> I think a tone and a direction of travel is much more useful than a curriculum or a prescriptive kind of way of looking at it, because I think that's something that will encourage people to look at attitudinal shift, and then the learning is secondary to that. The learning happens automatically when that's the attitude. (GP Partner, less than 5 salaried GPs, Scotland)

9.2.3 A more 'hands on' approach

Whilst the majority of employers, stakeholders and academics suggested the GMC use guidance and influence to bring about change to lifelong learning, there was a minority who suggested the GMC take a more 'hands on' approach.

Produce resources

One or two of those involved in the research believed that there was an opportunity for the GMC to produce more resources:

- Around reflection.
- Around mandatory training courses.
  - Note that a number of employers, stakeholders and academics felt that mandatory training packages were of variable quality.

> I think, firstly, their learning resources. Keep them coming, more of them, I personally love them …. Everything the GMC will produce, by and large, would be relevant to any type of doctors. (Stakeholder 11)

Hold trusts/health boards to account

One or two employers suggested that trusts should be held to account for the lifelong learning of doctors not in a training programme.

> First of all, I think the GMC ought to be holding us to account in trusts, in the way that we're held to account over trainees and undergraduates, we need an accountability mechanism, I would suggest, over lifelong learning. (Medical Director, NHS Acute Trust, North, England)

Single platform for recording

One or two of those interviewed put forward the idea of a single platform to record lifelong learning.

> Much more useful would be to have one single online data capturing platform which all doctors can use, which possibly all of us and the GMC can use…. rather than different organisations having different platforms. (Appraisal Lead, NHS Acute Trust, North, England)

Relicensing exams

Finally, there were one or two voices within the research that called for doctors to undertake a knowledge exam, rather than rely on doctors to provide evidence of their own lifelong learning.

10. Conclusions

This was a small-scale piece of qualitative research and not all employers interviewed were confident that they were fully aware of all the relevant processes underpinning lifelong learning within their organisation. However, there is an emerging picture of how lifelong learning is managed by organisations which employ doctors.

- It appears that organisations have no separate, formal lifelong learning strategies. Instead, lifelong learning is referenced within other strategy and guidance documents, to varying degrees.
- When asked where the responsibility for lifelong learning sits within their organisation, all the employers interviewed said that individual doctors have responsibility for their own lifelong learning as they are best placed to identify their learning needs. It was believed that doctors were influenced by appraisers, employing organisations and their Medical Royal College but that, ultimately, they followed their own path. In relation to the influence that the Medical Royal Colleges are thought to have on lifelong learning, there is some evident confusion (potentially arising from the lack of cut though of messaging) about the role that CPD points play in appraisal.
- Organisational processes reinforce the individual nature of lifelong learning as doctors working in trusts/health boards (not in a training programme) are typically able to access an annual sum of money for their lifelong learning alongside study leave. Doctors working in primary care did not appear to enjoy the same level of individual allowances for learning and were more likely to use their own money and time for lifelong learning. This potentially reinforces the perception of how lifelong learning is 'owned' by the individual doctor.
- Currently any challenge to individual doctors' decisions in relation to lifelong learning comes through the appraisal system, with the appraiser sometimes encouraging doctors to consider learning that might take them out of their comfort zone or to think about the needs of the community/future.
- Similarly lifelong learning was also evaluated at an individual level via appraisal – with no reports of systematic evaluation of the impact of lifelong learning occurring at an organisational level.

A reliance on doctors' learning being self-directed and individual doctors having clear responsibility for their own lifelong learning clearly has positives – it means that individual doctors have a degree of autonomy and control. They can decide on what learning they need and can channel their learning into what they are passionate about and what areas will help their future career progression. Any attempt to radically change this culture could run the risk of stifling innovation and demotivating doctors.

However, the focus on doctors' self-determination means that learning that is happening is potentially not always going to be what the trust/health board/practice

or the local community needs and there is no guarantee that doctors have the requisite skillset for the future.

Whilst there is some resistance to the GMC playing more of a prescriptive role in this sphere, there was felt to be a need for more guidance in specific areas. There was also thought to be an opportunity for the GMC to work more collaboratively with other healthcare regulators and the Medical Royal Colleges to communicate a consistent message and direction of travel around lifelong learning.

Finally, it is worth noting that COVID has brought about some positive changes to lifelong learning, in particular, making it more accessible to a range of doctors (through better quality, online opportunities) and reducing the pressure on doctors to submit CPD and check 'tick boxes' for appraisal (instead asking them to reflect more on everyday learning and experience). There was some call for these positives not to be lost post-pandemic.