Consultation on the GMC's role in continuing professional development

1. I write with regard to the GMC consultation on its role in continuing professional development.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation. The College supports the development of excellent continuing professional development (CPD) for GPs that balances the needs of individuals with the needs of organisations and that is ultimately more useful for improved patient care. The College, along with
partners in the Academy of Medical Royal Colleges, has done much work around CPD and revalidation¹.

4. This GMC report and accompanying guidance is very ‘high level’ and in its reiteration of various principles of effective education it is in line with the College’s approach. We welcome the decision not to mandate specific didactic approaches to education, and to focus the responsibilities on individual professionals and their employers / contracting authorities. There are a number of weaknesses apparent in the guidance however, and our respondents were generally critical of the lack of punch and focus in the draft. The GMC could go much further in endorsing the approach of the Colleges towards CPD, appraisal and revalidation – by advising doctors to follow their specialty College guidance, even if they are not themselves members of the College. By not doing so, we are concerned that the GMC is leaving room for doubt. Similarly, given the current and likely future climate in the NHS, and though we recognise the limitations of the GMC’s regulatory role, we feel there should be firmer guidance on the responsibilities of employers towards meeting employees’ individual CPD needs.

5. Specifically, there seem to be missed opportunities here. A role for the GMC in assuring regional input to support for doctors in accessing educational resources and appraisal / revalidation support will be essential. This is a clear audit role for the regulator to benchmark whether regional structures are effective for the equity issues outlined in paragraphs 78-82 of the Review paper – marginalisation of sessional doctors and self-employed groups such as GPs is a risk, as we have set out below.

6. We have reiterated some of these points in our responses to individual questions below:-

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

On the whole, we agree that the GMC should keep to providing a framework of principles and guidance and avoid micro-managing CPD activity. That said, we believe the GMC guidance should explicitly refer to the principles of CPD set

¹ See RCGP website, ‘Continuing Professional Development’ - http://www.rcgp.org.uk/professional_development/continuing_professional_devt.aspx
down by the Academy of Medical Royal Colleges and specialty Colleges, with their CPD credit system. The GMC mentions reservations over CPD that simply counts time-based credits. This is reasonable, but in the absence of alternative ‘hard’ measures there should be firmer support for the AoMRC approach. The RCGP CPD credit system\(^2\) supports the GMC guidance that individuals self-accredit their CPD based on time and a reflective record. However, the RCGP system also rewards GPs with extra credits if they can demonstrate implementation of learning in practice, to the direct benefit of improved patient care.

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

This is mentioned at several points, but we would argue that the emphasis is not sufficient. In particular, while it should be clear the ultimate purpose of CPD is to improve patient care, it is not clear from the guidance how CPD provision should be informed by the needs of patients, carers and the public.

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

We would argue for a somewhat stronger emphasis on CPD that addresses the needs of the team or organisation – particularly where doctors are leaders of teams or responsible officers.

4. **Does the guidance place the right emphasis on the role of appraisal and personal development plans in guiding doctors’ individual CPD activities?**

The emphasis on appraisal is appropriate, but there should be more sense of appraisal as an ongoing cycle, involving the identification of needs, the assessment of appropriate CPD and the measuring of progress towards meeting needs. As discussed elsewhere, appraisal for locums may be a particular weakness, and more detailed guidance in this respect would be of use.

---

\(^2\) See RCGP, Guide to the Credit-Based System for CPD (RCGP 2010) - [http://www.rcgp.org.uk/PDF/Credit-Based%20System%20for%20CPD_2nd%20version_110110.pdf](http://www.rcgp.org.uk/PDF/Credit-Based%20System%20for%20CPD_2nd%20version_110110.pdf)
5. Is the guidance sufficiently clear about the responsibilities of employers and contractors in supporting doctors’ CPD activity? If not, what more is required?

The guidance is reasonably clear as to what the responsibilities of employers and contractors are, but it is less clear how these responsibilities would be enforced. It will be imperative for the GMC to impress the importance of this on the systems regulators to whom employers are accountable. The danger is that, in financially difficult times, employers will not feel compelled to provide the necessary support to individual doctors to achieve personal and professional development through CPD.

The GMC could strengthen this section by endorsing the AoMRC approach to CPD credits, which would make clear to employers the expectation on them to support doctors in achieving their CPD objectives as identified through appraisal. By not doing so, the GMC leaves it too open for employers to apply their own priorities in the extent to which they support CPD. In current circumstances, many doctors already report difficulties in obtaining funding or backfill for CPD activities, and the GMC should not miss an opportunity to address this.

6. Do you think there are any barriers stopping employers and contractors from carrying out their responsibilities? If so, what are they and how could they be overcome?

As already mentioned, current and anticipated financial constraints are a significant barrier that will hold some employers back from meeting their responsibilities. This is already observably the case, and is very likely to be more so given NHS funding issues and proposed reforms of workforce training. In particular, it may be especially difficult for doctors to obtain external CPD, as opposed to the in-house or electronic varieties – and this external CPD, involving collaboration and conversation with peers, is vital in maintaining good practice. In this context, the GMC’s emphasis on carrying out a variety of CPD activities in a variety of settings is to be welcomed.

There are major implications from the proposed changes to workforce education and training, and these pose risks for general practice CPD in particular. There is a concern that Local Education and Training Boards (LETBs) will be disinclined to support GP tutors, which may put at risk early educational intervention in GP
performance issues. In the absence of GP tutors, the danger is of primary care CPD becoming parochial, only addressing local needs rather than broader professional needs of the staff involved. As GPs currently often host multiprofessional learning activities for other primary care staff, this may also put the CPD of other professionals in the primary care team at risk.

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

   It is imperative that revalidation is primarily a development process and we need to ensure that reflection is considered to be an essential element of the CPD framework. In general, this guidance does provide sufficient information, but there are important areas that still need clarifying, such as: how or if the GMC will audit CPD for revalidation; what will be the sanctions for someone not participating in 50 credits of CPD; the minimum number of CPD credits or activity for a part-time doctor or someone taking a career break, and; what happens if the supplied information is insufficient. In our opinion, the GMC should actively encourage doctors to follow their college’s guidance.

8. **Do you think we have identified the most effective ways of embedding the guidance into local processes? If not, can you suggest any other ways that will help make sure our approach to CPD is effective and reflected within local processes?**

   Yes, we are generally happy with the identified ways of embedding the guidance into local processes. There is, however, an issue around how much employers are really aware of what is happening and what their responsibilities are.

9. **Do you agree that there is a role for the GMC in bringing to doctors’ attention information about emerging trends or developments in medical practice and professionalism in order to help them reflect on their CPD needs? If so, are there particular topics, themes or aspects of professionalism where this might be helpful, or specific groups of doctors for whom this might be useful?**

   If you don’t think the GMC has a role in this area, please explain why not.

   Yes, we would agree that the GMC should have a limited role in this area, where it has particular professional expertise, or where CPD needs cross the usual professional boundaries. We would suggest specific areas might include:-
elements of Good Medical Practice; confidentiality; medical ethics; medical regulation itself; government initiatives; commissioning; initiatives in integrated care; issues around economic and population change.

There is some concern at the proposal to reflect back to individual doctors about potential learning needs based on GMC database information – this would have to be very carefully trialled and done with the full cooperation of the Academy and Colleges. Not least, the danger is that such information, being always retrospective, might lead to inappropriate CPD provision.

10. Do you think that our proposals as a whole (the guidance, the plans for incorporating the guidance into local processes, and the proposals for bringing to doctors’ attention information which may be relevant to their CPD) will help recognition of doctors’ CPD needs? If not, how might we address this better?

Yes we do, with the reservations mentioned above.

11. Are there any groups of doctors upon whom our proposals might have an adverse effect? If so, which groups would be affected and how might we address this?

The proposals themselves should not have an adverse effect on specific groups; but they do not go far enough in recognising the specific circumstances of groups such as locum and sessional doctors and those working temporarily overseas, and the guidance fails to provide sufficient support for these. Numbers of sessional doctors will increase under proposed NHS structures, and unless processes are developed for their CPD there is a growing danger that they could be marginalised.

In particular, by not taking a clear position on Colleges’ approach to CPD credits, the GMC fails to resolve uncertainty over what lever CPD activity should be expected of part-time GPs.

12. Our report contains nine specific recommendations on the role of the GMC in regulating doctors’ CPD. Do you have any other comments on the conclusions of the review report and the report recommendations?
We are generally happy with these recommendations, though we feel they should reaffirm that CPD is primarily a developmental process and that reflection should be considered an essential element of the CPD framework.

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

It is suggested that the GMC might consider auditing CPD folders to ensure accuracy, or else establish this as a duty of the Responsible Officer.

7. We gratefully acknowledge the contributions of the College’s Professional Development Board and members of College Council in formulating this response

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council