Agenda Item 26

Enclosure 24

Paper ETC 24/03

Education and Training Committee

CONTINUING PROFESSIONAL DEVELOPMENT:
SETTING UP A PROFESSIONAL LIAISON GROUP

from the Secretary

for discussion and approval

Executive Summary

This paper proposes a Professional Liaison Group (PLG) for Continuing Professional Development (CPD) and sets out its rationale, terms of reference / project brief, plan of activities and timetable, budget and legal context.

1. Introduction

In its response to the feedback from the consultation paper the Council stated,

" **7. Professional advice**

In your comments on the Council's proposals relating to professional advice, you were strongly supportive of the principles underpinning its proposals to establish Professional Liaison Groups (PLGs).

The Council has therefore decided that both the Council and its committees will be able to establish PLGs, primarily to provide advice on strategic issues. It has decided that all PLGs will be project based, that they will have a flexible format, that they will have a defined lifespan for specific purposes, and that each PLG will always have :

> A rationale (a ' mission statement ')

> Terms of reference

> A plan of activities

> A timetable

> A budget

The Council thinks it is important to retain as much flexibility as it can, because of the variety of issues on which it might want to seek advice. In particular, it has decided that the membership of a PLG should vary depending on its needs. Therefore, a PLG may need members who can provide expert opinion, members who represent organisations or a combination. Equally, a PLG's membership may need to be uni-professional or multi-professional, and it may need to be supplemented by educational institution representatives, employer representatives, patient/clinet/user representatives, lay members, or other representatives or experts. The convenor of a PLG will normally be a Council Member. "

2. Need for Professional Liaison Group on CPD

At its meeting on 21 January 2003 the Council discussed and approved the attached paper and an oral presentation from Professor Sir John Lilleyman.

The Council's report is

" 6.2 Professor Lilleyman had chaired the Academy of Medical Royal Colleges Directors of CPD Committee.

6.3 Professor Lilleyman noted that it had been very apparent during the consultation that Continuing Professional Development was a major cause for concern among registrants many of whom felt that it would be expensive and time-consuming.

4 The medical profession had six years experience of CPD and could share problems ...id successes with other professions. Medical Education was a continuing process of lifelong learning. Continuing Professional Development had emerged out of Continuing Medical Education and was an important tool in gaining and maintaining public confidence and underpinning clinical governance. Doctors were required to undertake CPD by the General Medical Council (GMC) and by their employer as part of their annual appraisal and under the rules of clinical governance.

6.5 The GMC tentative definition of CPD was that it was a continual process to allow doctors to develop attitude, skills and knowledge to support standards of practice. A new feature of the scheme was that doctors had to define, recognise and collect the evidence that they were undertaking CPD.

6.6 The Royal Colleges had implemented CPD schemes and provided guidance and an administrative framework to collect evidence and some form of quality assurance. The Royal Colleges issued guidance on areas which would be regarded as relevant CPD but the individual doctor was given the freedom to collect what they felt was relevant. CPD was based around a system of credits which were for the most part self-policed and self-audited. The Royal Colleges conducted random audits to check the evidence collected and if this was appropriate to the practice of the doctor concerned.

6.7 There were 8 central planks to good clinical care: These were as follows:

(i) Good Clinical Care
Be there and be conscientious

(ii) Maintaining Good Medical Practice
Keeping up to date

(iii) Teaching and Training
Making assessments/references

(iv) Relationships with Patients
Obtaining consent
Confidentiality
Communication

(v) Dealing with Problems
Badly Performing Colleagues
Complaints/litigation

(vi) Working with Colleagues
Team working
Cover Arrangements

(vii) Probity
Research
Conflicts of Interest
Money

(viii) Health
Danger to Patients

6.8 It was likely that the HPC's role in the implementation of CPD would be to take part in the quality assurance process. The HPC would probably work with the professional body in this. An area which of difficulty was the quality assurance of outcomes i.e. had CPD actually improved the registrants practice.

6.9 The Council noted that a major area of concern to registrants was that those who were not gaining clinical experience but who were working in other areas such as management or research would be stuck off the register because they could not provide evidence of CPD in clinical practice.

6.10 A concern to Prosthetists and Orthotists was that those practicing in one area of their profession i.e. prosthetics or orthoptics would be unable to provide evidence of CPD in the other area and would no longer be able to call themselves a Prosthetist or an Orthotist

6.11 The Council noted that there was concern among registrants that those who wished to take a career break would be unable to keep up their CPD. It also noted that the Order in Council gave the HPC the power to require individuals wishing to come back onto the register to undertake a period of retraining.

6.12 The Council agreed the Education and Training Committee should establish a professional liaison group to consider CPD and to report back to the Council."

This forms the rationale for the proposed Continuing Professional Development Professional Liaison Group.

3. **Composition of the Professional Liaison Group**

The Committee is asked to set up a multi-professional Professional Liaison Group on CPD. The membership from HPC members' side is recommended as :

Christine Farrell	Prof. Sir John Lilleyman
Diane Waller	Ms Gillian Pearson
Graham Beastall	Prof. Norma Brook
Michael Collins	

The Committee asks the PLG to make recommendations on additional lay, educational, and employer membership as appropriate.

From the professional bodies' side it is recommended that the AHP CPD project steering group be invited to nominate 7 members from the professional bodies.

4. **Timetable and Plan of Activities**

The PLG should meet expeditiously and then plan a schedule of meetings. Members' commitments over Spring 2003 will need to be taken into account.

The key known dates include :

- April 2003, relaunch of HPC with new powers, including over post-registration education and training and their linkage to conduct procedures,
- June 2003, report from the AHP CPD project,
- 2005, consultation by HPC on a CPD scheme,
- 2006, HPC CPD scheme comes into force.

The PLG will need to hold its own meetings, receive and perhaps commission advice and hold consultation meetings between 2003 and 2006. It will need to give careful consideration to publicising and launching the eventual scheme.

At some point during the timetable it is hoped that the NHSUniversity in England and its equivalents elsewhere in the UK, the DH and the other UK Health Depts will clarify their position on the provision they intend to make for registrants (whether NHS employees or others) in terms of support such as financial, time off, on-site tuition, or whatever. The PLG will need to take account of this wider environment, and the President is already engaged with DH's project on a post-registration qualifications framework.

5. **Project Bid for CPD under the Health Professions Order**

Following the Council's consultation exercise in 2002 the Council issued this statement on CPD :

" When and how will Continuing Professional Development come into effect ? "

Council has decided that CPD will be linked to registration as people supported this in principle. It will not come into effect for at least 3 years however. Council has decided to hold another consultation on this within two years when it will set out its proposals in more detail.

The Council has already decided however that among other things CPD should take account of the needs of part-time and self employed registrants. It should also take account of the work others such as the Allied Health Professions are currently doing in this area. "

The Committee is asked to re-endorse this together with a further four principles for the process :

- the consultation venues to be in education institutions,
- the CPD scheme to be a generic multi-professional process,
- the cycle for undertaking CPD to be set at four years,
- and
- HPC to approve, assure, and monitor the scheme but not be the delivering body as well.

These principles should be consistent with the work on CPD now in hand in the Allied Health Professions (AHP) and at the Department of Health (DH).

6. **Legal Advice**

The Solicitor to the Council has already advised on the Council's powers on CPD and on (assessment of) continued competence (for fitness for practice). This advice is appended and forwarded to the PLG.

7. **Budget**

A budget for the PLG has been established. This envisages four meetings over the next financial year with other activities such as study visits and conference attendance.

Recommendation

The Committee is asked to approve these proposals and set up the PLG on this basis.

THE ACADEMY OF MEDICAL ROYAL COLLEGES.

Continuing Professional Development: The ten principles.

Continuing professional development (CPD) is the process by which individual doctors and dentists keep themselves up to date and maintain the highest standard of professional practice they can achieve. The vast majority are good learners and have always practised CPD without calling it that, but now the NHS, the GMC and the GDC will require documented proof of it as an essential component of the information needed for successful appraisal and revalidation. CPD "belongs" to the individual, and is not "run" by any agency, but there is a need for the organised collection of evidence of appropriate activity together with some audit of the adequacy of any individual's programme. To facilitate these requirements, the Colleges and Faculties of the Academy of Medical Royal Colleges have all developed CPD schemes for their members and fellows. The organisations concerned are uniquely placed to do this since their main function is to uphold standards of practice. Presently, however, the schemes they offer vary in complexity, bureaucracy and structure.

It would be easier for those involved in appraisal and revalidation if the variation was confined to what doctors or dentists did rather than how they recorded their CPD. This could largely be achieved by adopting a common framework within which individual colleges and faculties can develop guidelines on appropriate activities in their relevant areas of expertise. Ideally, such a framework should be as simple as possible, focusing on quality assurance through audit rather than bureaucratic processes of data collection, and as CPD schemes evolve they will increasingly focus on the outcome of an individual's programme in terms of its effect on clinical practice. Some colleges, particularly the RCGP, have travelled further in this direction than others.

Presently All College/Faculty schemes are based on acquiring credits. The advantage of this system is that the time devoted to CPD can be measured and recorded. The disadvantage is that it is totally insensitive to the quality and relevance of the various CPD activities. Effective CPD schemes are flexible and largely based on self-assessment so that doctors can develop what they do in the context of their individual professional practice while also being able to prove they are doing so when subjected to external scrutiny. There is no single 'correct' or best way of doing CPD and the methods chosen will depend on spheres of practice and personal preference. They may range from multiple-choice questions and journal reading through case discussions, seminars and symposia to visiting other departments or centres[1,2]. Generally, learning that occurs in the context of the daily workplace is more likely to lead to better practice[3].

The principles underpinning CPD schemes therefore need to be as simple as possible while providing a good foundation on which to build an appropriate portfolio unique to the individual doctor. The Academy has agreed 10 principles as listed on the following page, which it believes meet these criteria. They also comply with the aims of a CPD programme as outlined in the Basel Declaration of the UEMS, these being (a) to improve the safety and quality of medical practice, (b) to encourage the principles of life-long learning, (c) to make transparent the outcomes, processes and systems required for successful implementation, and (d) to audit progress.