The University Of Sheffield.

A study to assess the impact of continuing professional development (CPD) on doctors' performance and patient/service outcomes for the GMC

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1. Introduction

The Academic Unit of Primary Medical Care, University of Sheffield, in collaboration with Capita Health (previously known as Tribal Health), a division of The Capita Group Plc were commissioned by the GMC to assess the impact of continuing professional development (CPD) on doctors' performance and patients/service outcomes.

1.1. Background

Lord Patel's report 'Recommendations and options for the future regulation of education and training' published in 2010 recommended that the GMC should review its 2004 CPD guidance and re-examine how its regulatory role in CPD should be exercised. The report identifies areas where regulation may be enhanced and options for how this might be achieved. In relation to CPD the report makes the following recommendations:

- The GMC should develop a regulatory framework for the education and training of doctors in career posts. Such a framework would not only be in the interests of the doctors concerned (who are often disadvantaged by limited access to training and CPD opportunities), but it could also provide reassurance that these doctors are meeting national standards overseen by the regulator.
- As a minimum the GMC should provide clear guidance on what doctors will be required to do to keep up to date for the purpose of revalidation and the role of CPD within that. At the same time, the GMC will need to recognise the individual nature of CPD and avoid rigid requirements which may undermine what is most valuable for individual professionals.

The College of Emergency Medicine, Manchester Metropolitan University and the Federation of Royal Colleges of Physicians were commissioned by the GMC in 2010 to explore the effectiveness of CPD using surveys, interviews with CPD leads and shadowing. A very wide variation in the type of CPD undertaken was found reflecting the personal nature of CPD.

The GMC has recently conducted a consultation on a revised version of 'Guidance on Continuing Professional Development [CPD]' which sets out the principles on which CPD should be based and the roles of the relevant organisations involved in its' delivery.

This report uses the GMC definition of CPD as being a 'continuing learning process' that complements formal undergraduate and postgraduate education and training. It requires doctors to maintain their standards across all areas of their practice [nb 'practice' includes all the professional roles that doctors currently perform and those that they plan to perform]. The GMC also believes that CPD should encourage and support specific changes in practice and career development and play a role in helping doctors to keep up to date when they are not practicing.

In June 2012 the GMC published new guidance on Continuing Professional Development. (See http://www.gmc-uk.org/CPD_guidance_June_12.pdf_48970799.pdf) The current guidance identifies the key principles for CPD and provides a framework for guidance on what doctors are expected to do to maintain and improve their practice through CPD. It outlines the standards that doctors across the UK are expected to meet in planning, carrying out and evaluating their CPD. It recommends that doctors take primary responsibility for their continuing learning by setting out their goals in personal development plans, job planning and appraisal although it does not prescribe a formal curriculum or specify the amount of CPD required. It also clarifies the role of the GMC, the employer, responsible officers, system regulators and medical Royal Colleges.

Of particular note, it says that employers have a responsibility to create an environment that provides opportunities for all staff to maintain and develop their skills. It also talks about planning CPD to meet the needs of others including patients, teams, the organisations where they work and the wider community. The guidance also specifies that doctors must try to identify ways in which CPD activities could help to improve the quality of care for patients and the public.

1.2. Research Specification

The following domains were used as the framework for the enquiry:

- the role of CPD for doctors and its impact on the wider environment
- the broad implications of CPD and the benefits it may have for individual doctors, the wider team, colleagues and multi-professional teams, patients, employers and organisations.
- the impact on doctors' confidence and competence in their day to day work and ability to deliver high quality care
- how CPD may help doctors stay engaged and strive towards excellence.

2. Methodology

2.1. Key questions

This project addressed five key questions:

- How does doctors' participation in CPD affect their practice and performance?
- How does participation in CPD contribute to improvements in patient or service outcomes?
- Can you identify examples of good or innovative practice in CPD?
- Can you identify examples where CPD may have contributed to changes to an individual's practice and/or changes to the way care is provided either by a team or individual?
- Can you identify examples of barriers encountered by individuals or organisations when implementing aspects of or learning from CPD and how these barriers were overcome?

2.2. Research Design

The project used a multi-site sampling frame with semi-structured telephone interviews and in-depth interviews. A "realistic" evaluation methodology was used for thematic analysis (Pawson and Tilley, 1997) and approached Acute Trusts, Mental Health Trusts, and Primary Care settings. Additional primary care sites included Deanery interviews, Medical Education departments and CPD trainers.

60 interviews were conducted. The tables below show the different types of organisations and countries covered.

Interviews completed to date by type of organisation

Organisation	No.
Acute (hospital) trust	13
Mental Health Trust	8
Primary Care Trust	10
Clinical Commissioning Group (CCG)	2
Other territories	5
Royal Colleges	9
Deaneries	13
Total	**60**

Interviews completed to date by country

England	46
N. Ireland	1
Scotland	2
Wales	2
Royal Colleges	9
Total	**60**

1.1. Methodological issues

Historically there has been little work which addresses the actual impact of CPD for doctors on practice and service. Given the presence of many extraneous variables, we did not feel that it would be possible to quantitatively demonstrate the relationship between participation in CPD and the impact on practice, service or patients. There are difficulties in objectively assessing the impact of CPD on practice, service and patient experience as there are simply too many other variables which could account for variations in practice and service etc. This difficulty is analogous to that spelt out in the MRC framework for the evaluation of complex interventions[1]. CPD is equivalent to a complex intervention and as such traditional quantitative methods cannot be employed to understand its impact.

This multi-site case study approach has enabled the questions to be addressed in the context of the real world[2]. This approach is underpinned by the methodological framework of realistic evaluation (Pawson and Tilley 1997[3]) which focuses upon both the object of the research and also the context within which it operates, to provide a rich picture of what works, for whom, and why (or why not); taking into account the different organisational settings, different specialities and teams to understand the impact of CPD on performance, practice and service delivery.

2.3. Sampling approach

We took a two stage approach to sample selection with an initial wave of screening interviews to identify potential case studies followed by the actual case study fieldwork. We used a sampling framework to maximise diversity of the settings in terms of:

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[1] MRC. A Framework for the development and evaluation of RCTs for complex interventions to improve health. April 2000.
[2] Grbich (1999) Qualitative Research in Heath. London: Sage.
[3] Pawson R and Tilley N. (1997) Realistic Evaluation. London: Sage.

- Acute trusts: urban, semi-urban/ rural; district general hospitals; teaching hospitals; size of trust (number of employees)
- Mental Health Trusts: urban; rural; size of trust (number of employees)
- Primary Care Trusts and Clinical Commissioning Groups

The trusts were selected using software to generate a stratified random sample as follows:

- 35 acute Trusts
- 10 mental health Trusts.
- 35 primary care settings.

The first wave of interviews were held with Medical Directors, Trust CPD leads, Royal College CPD leads, Heads of Medical Education, HR managers, Heads of Medical Education, local CPD trainers and Deanery staff.

The first wave of telephone interviews using a semi-structured topic guide was adapted to suit a range of settings. Identification of potential case studies proved challenging , identification and recruitment of case study sites was slower than anticipated and in many cases, particularly in hospital based specialities, respondents were unable to think of any CPD which could be used to form a suitable case study. Respondents in primary care were more likely to be able to think of relevant illustrative CPD case studies which might demonstrate 'impact' but in order to minimise participation bias we repeatedly contacted potential sites from other specialities to maximise participation across as diverse a sample as possible.

2.4. Case Study Sites

The original aim was to recruit 30 case study sites; with ideally 10 in primary care and 10 in secondary care, and 10 additional case studies to be allocated as exemplars. 23 case studies were completed:

- Primary care – 9
- Secondary/Tertiary Care – 10
- Mental Health – 2
- Across all services - 2

One case study was set in Scotland and one was set in Wales. We did not identify a case study in Northern Ireland. The remainder were all based in England or covered the whole of the UK such as the RCGP.

Interviews were conducted by experienced qualitative research interviewers , using the topic guide (see appendix) with a range of different respondents including the training providers, the doctors in receipt of the CPD, the course organisers, Trust managers, commissioners, audit staff, clinical staff and where possible patients .

The number of interviews carried out at each site varied according to the particular case and the number of individual doctors who had undertaken a specific CPD programme. Outcome data were also collected and analysed where appropriate.

2.5. Data Analysis

All interview notes and case studies were coded and analysed in NVivo software for further analysis. Qualitative analysis was independently undertaken, by the study authors using the constant comparison methodology to derive the main themes and codes[4]. Following each interview, transcripts were read, and emergent content units were identified, coded, and grouped into themes and later compared across the groups. Each content unit was linked to a referenced item of original data. A number of key themes and sub-themes have emerged from the data. Each main theme and sub-theme has been illustrated with quotations.

Analysis meetings were held between all the study authors that included discussion of the challenging of interpretive analysis within the coding framework. Consideration of reflexivity and potential researcher bias were important; the team comprised two academic general practitioners and a senior social sciences/ health policy qualitative researcher.

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[4] Strauss and Corbin. (1997) Grounded Theory in Practice. London: Sage.

3. Main Findings

3.1. Thematic analysis

We identified seven key themes as follows:

- The impact and benefits of CPD
- Barriers to CPD
- Barriers to the implementation of learning from CPD
- Facilitators of the implementation of learning
- Overcoming Barriers /Lessons learnt
- Trust and Royal College Perspectives of CPD
- Cultural differences between Primary and Secondary Care with regard to CPD.

Below is a summary table showing the key themes, associated sub-themes and illustrative quotes.

Table 1: Summary of themes, associated subthemes and illustrative quotes

	Summary of themes, associated subthemes and illustrative quotes
Theme 1: **Impact and benefits of CPD** **(Case Study Perspectives)**	**a) Anecdotal or qualitative** ' An increased confidence in knowing when to prescribe patients to dementia services such as the Memory Clinic' (GP, Dementia Education Case Study 5) 'One of key messages, they're keen to see people as (referred) early as possible so that has changed practice. It helped me clarify when I should go down the Research Institute for the Care of the Elderly route rather than the mental health route, (it has) helped on that front' (GP) **b) Harder outcomes:** 20% decrease in referrals to secondary care for spinal pain (GP, Musculo-skeletal Case Study 14)
Theme 2: **The barriers to undertaking CPD**	**a) Time, workload** "Time and resource. For example, to attend CPD sessions, have to leave practice early, or GP has to come in on their half day' (GP) **b) Funding issues** 'Costs incurred in getting locum cover'. (GP)
Theme 3: **Barriers to implementing CPD learning in practice**	**a) Time** 'Time is a major pressure on Consultants in respect of applying learning from CPD activities in that as soon as they return from any length of study leave they are right back in the front line seeing patients' (Consultant, Acute Trust, Case Study) **b) Tick box mentality** "CPD has not been tied into the appraisal process. It has been mainly a tick box to ensure you get enough points rather than looking at what CPD you actually did." (Large Acute Hospital, Medical Director) **c) Idiosyncratic approach to CPD** The Trust regarded Consultants CPD as their own personal responsibility and so long as they met the Royal College guidelines etc. that was sufficient (Medical Director, Mental health Trust). **d) Opportunity to implement learning** 'It is difficult to quantify the impact of the training since the events being trained for are very rare and so it would not be possible to measure a difference in the number of critical incidents. (Consultant Anaesthetist, Acute Trust, Continuing Scenario Based Anaesthetic Resuscitation Training COSBART Case Study 3)
Theme 4: **Facilitators of the implementation of CPD**	**a) CPD linked to appraisals and PDPs** 'We have close links with GP tutors, and have 8 senior appraisers who are there to provide input, to help people struggling with CPD and revalidation. We also have targeted CPD for appraisers, to ensure that they continue to develop.' (Deputy Medical Director, PCT) **b) Reflection** 'Reflective practice is what every doctor needs to do in order for CPD to have an impact.' (Health Board) **c) Role of Royal Colleges** 'The College is considering whether or not it should contact the Trusts who employ the Consultants who refuse to engage in the audit process for CPD. (RC of Paediatrics and Child Health) **d) Role of Deaneries** 'Staff Grades and Associate Specialists (SASG) are a vulnerable group of doctors and need support to access CPD' (SASG lead for Frontier Programme, Frontier Programme Case Study 10) **e) Revalidation**

	'With the introduction of GP appraisals and revalidation British Association of Sessional Doctors (BASD) recognised that locums and sessional GPs need some extra support to fulfil all the criteria that are required for a GP to gain revalidation' (Course Leader, *Bristol Association of Sessional Doctors (BASD), Case Study* 17)
	f) Able to test new knowledge without fear or failure or exposure *'I think the most valuable thing is the networks you establish in a non-threatening environment, to question your own practice' (Consultant, Secondary Care)*
	g) Case based audit *'Give action points at appraisal – carrying out an audit might be an action point' (Deanery)*
	h) Benchmarking *'The e-learning module produces Challenge Benchmarking Graphs so that GPs can compare their scores with others.' (RCGP, Case Study 8)*
	i) Financial incentives *'There was some funding from North Tyneside PCT, which was available for the course organisers to use to give a financial incentive to practices to get involved.' (PCT)*
Theme 5: **Overcoming barriers/** **Lessons Learnt**	**a) Time and effort required** *'In retrospect I did a lot of this work myself, which took a fair chunk of my time. It could be possible to delegate this to team members with some planning beforehand I think, if they were properly briefed.' (GP, Case Study 2)*
	b) The need for ongoing support over and above training *' Different GPs have different levels of confidence and some need more support than others, particularly the single handed GPs" (End of Life Commissioner, DNACPR Case Study 6)*
	c) Using routinely collected data to measure outcomes *'The course organisers found that routine documentation can be used to support both the implementation of learning and also audit the implementation itself. In this case the drug chart was re-designed to act as a prompt to implement actions which had been covered by the CPD' (Medicines Management CPD, Case Study11)*
	d) Simplicity *Simplicity and repetition is preferable to complexity' (Consultant, Acute Hospital, Case Study 3)*
	e) Learning with peers *'The crucial importance is of learning with peers rather than with experts who impart knowledge. In the Practice Based Small Group Learning (PBSGL) participants build from their own knowledge base. An expert coming in does not result in the same kind of learning experience.'(Deanery training for GPs, Case Study 15)*
	f) Targeting of CPD *'Those doctors that turn up at optional educational events tend to those that are most interested in the topic and those that most require training do not attend.' (PCT Commissioner referring to GPs, Case Study 6)*
	g) Winning hearts and minds *'A challenging aspect of this project was to achieve a consensus between different parties including general practitioners, the acute teaching hospital and the community provider.' (GP in reference to CPD requiring change across many services, Case Study 14)*

Theme 6: Trust/Royal College perspectives of CPD	a) **Maintaining status quo** *'The main benefit of CPD was seen as enabling doctors to maintain their skills' (Royal College)*
	b) **Lack of evidence for CPD** *'How much of a difference CPD makes to a doctors practice is very difficult to assess – in some cases CPD is just about collecting points for revalidation and appraisal. Significant amounts of research would be required to assess the true impact of CPD on doctor's performance etc. as it is very difficult to evaluate. (Medical Director, Mental Health trust)*
	c) **Role of the RCGP** *'The system is designed to demonstrate they use their learning. They can do this in various ways either with case scenarios, event analyses or audit.' (RCGP Case Study)*
	d) **Expectations of appraisal process/ revalidation** *'There will be more robust appraisal procedures with revalidation' (Acute Trust)*
	e) **Focus on technical skills** *Doctors here are mainly interested in doing CPD in technical stuff – latest widgets, laser techniques etc. They are not interested in things like communication skills. CPD does not cover balanced skills.' (Medical Director, Acute Trust)*
Theme7: Cultural differences between Secondary Care and Primary Care	a) **Extent to which CPD is linked to the appraisal process** *'We make no attempt to link CPD with their performance'(Medical Director, Acute Trust)*
	b) **Extent to which CPD is selected according to the needs of the individual versus the needs of the organization or the wider community** *All doctors applying for funding for CPD from the Frontier Programme need to show that the CPD is in their Personal development Plan and they must have a supervisor who will support their application. They need to demonstrate links to organisational objectives as well as personal objectives. (Frontier Programme Lead)*
	c) **The extent to which reflection is undertaken** *'It is essential that reflective learning forms are available on the Bath GP Education website, which prompt GPs to not only think about what they learnt but how to implement their learning in their day-to-day practice' (GP Course leader, Case Study 5)*
	d) **The type of CPD e.g. multi-disciplinary** *'This diversity was perceived as a positive move and meant that the groups were able to explore issues from a multi disciplinary perspective' (Deanery in relation to GP training, Case Study 16)*
	e) **Tick box mentality** *"Good CPD and PDP hinges on an appraisal with a good appraiser who will challenge you leading to more challenging CPD rather than just tick box CPC." (RCGP)*

3.2. Theme 1: The impact and benefits of CPD

The evidence of benefits derived from CPD identified in the case studies is wide ranging from the anecdotal to hard outcomes which can be measured. It is generally assumed that all the case studies led to an increase in knowledge and skills. We know that there is a general belief that all CPD will have benefits and will eventually be implemented but demonstrating this implementation of the learning is more difficult. One course leader in a case study said:

'Formal assessment of CPD is an incredibly difficult thing to ascertain. Measuring any particular CPD would be lost in the general background of other variables. Everybody does

it, there can be no control group. Basically we undertake medical activity and hope that some will stick. We try hard to keep up to date but we don't specifically measure outcomes.' (Consultant, Acute Trust)

For some of the case studies it was 'too soon' to identify hard outcomes and so only anecdotal feedback was available at the time with an expectation that clear outcomes would be measurable over time. In other cases the event that the doctors were being trained to deal with was so rare that "hard outcomes" would be very difficult to generate, for example with the COntinuing Scenario Based Anaesthetic Resuscitation Training known as COSBART. In COSBART initiative Consultant Anaesthetists were specifically trained to deal with rare emergency scenarios. Those Anaesthetists who undertook this training felt very strongly that the CPD was beneficial to their practice by making them work through particular scenarios as a team and making them ready to cope should a particular situation arise. Similarly with Advanced Life Support Group Training, with the courses on the Major Incident Medical Management, it might be sometime before a course participant was ever in a position to apply their new knowledge/skills.

The impact or benefits of the CPD were identified from a variety of sources:

- Interviews with the participants themselves
- Interviews with the participants' managers
- Interviews with the course leaders/organisers
- Audit data
- Reflective accounts/ feedback completed by course participants, some time after the course was completed.

The table below summarises the key benefits identified for each case study.

Table 2: Summary of benefits of CPD by case study		
Case Study	Setting	Benefits
1. Advanced Life Support Group Training	Predominantly secondary care for emergency medicine and paediatrics. Some provision for GPs	86% of respondents from the Advanced Paediatric Life Support course had put the skills that they had learned on the course into practice and 76% of those commented that the skills they had learned were very or extremely useful 100% of respondents from the Managing Obstetric Emergencies and Trauma course had put the skills into practice and 87% commented that the skills they had learned were very or extremely useful Plus anecdotal feedback on a large scale
2. Coeliac disease Guidance	Primary Care: GPs	Revised guidance Review of prescriptions Cost savings to the PCT
3. COntinuing Scenario Based	Secondary Care - Anaesthetists	"It makes you practice drills that you would never do normally. When a situation arises, you are fresh, having actually

Table 2: Summary of benefits of CPD by case study		
Case Study	Setting	Benefits
Anaesthetic Resuscitation Training (COSBART)		performed it just a few months before."
4. Community DVT Clinical Pathways	Primary Care: GPs	Anecdotal: Increasing awareness of services Improving adherence to the referral pathway
5.Dementia Education	Primary Care: GPs	Anecdotal: An increased confidence in knowing when to prescribe patients to dementia services such as the Memory Clinic A better understanding of the drugs that are prescribed for people with dementia An increased awareness of the services available
6.Do Not Resuscitate Cardiopulmonary Resuscitation (DNACPR)	Primary, Community and Secondary Care	The End of Life Register in the community shows a significant increase in the number of DNACPR orders issued. In the last 9 months of 2011 there were 99 DNACPR orders made and in the first six months of 2012 this increased to 230 DNACPR orders.
7.Educational Leaders Course	Secondary Care	Anecdotal: Course leaders have conducted a 12 month follow up of course participants based on interviews with the first cohort.
8.Essential Knowledge Updates	Primary care	Anecdotal on a large scale (Approx 8,000 GPs complete each 6 month module) GPs that complete the Updates and pass the self assessment test are asked what they will do differently having completed the learning.
9.External Quality Assessment (EQA) in Pathology	Secondary care: Pathology	EQA provides both education and quality assurance. It is way of ensuring consistency across professional groups and identifying poor performers.
10.Frontier Programme	Secondary Care	Increasing the confidence of SASG doctors and their willingness to take up leadership roles.
11.Medicines Management	Acute Trust: All doctors	Reduction in prescribing error and an overall improvement in compliance.
12.Mental Health Law Training Programme	Mental Health Trusts: Psychiatrists	Anecdotal *"The vignettes ....were helpful in boosting my interest in these clinical situations to serve patients better".*
13.Mental Capacity Act Training	Mental Health Trusts: Psychiatrists	Mental Capacity Act and Deprivation of Liberty Safeguards activity increased by 101% from March 2011 to March 2012.
14.Musculo-skeletal Pathway	Across primary and secondary care	95% adherence to new referral pathway. All referrals for spinal care to secondary care are now triaged by physiotherapists. Direct referrals to secondary care dropped to zero. More appropriate and targeted therapy. 20% decrease in referrals to secondary care for spinal pain. Number of patients referred to surgical teams has halved. The surgical conversion rate has increased from 20% to 50%.

Table 2: Summary of benefits of CPD by case study		
Case Study	Setting	Benefits
15.Practice based small group learning	Primary care: GPs	Qualitative study stressed the importance of the learning environment being conducive to learning and change. Clear finding that participants in small group learning in practice said they had applied their learning to their practice.
16.Practice Leaders programme	Primary care	Increased confidence in leading and implementing service improvement projects. Numerous examples of service improvement. Also examples of participants taking on new leadership roles in CCGs.
17.Reflective Practice for sessional doctors	Primary care: sessional and locum GPs	Anecdotal: The opportunity to reflect on clinical problems, challenging cases and significant events with other GPs in the same situation
18. Regional course for Royal College of Psychiatrist exams	Secondary care	Anecdotal: Pass rates improved from 35% to 50 – 60%.
19. Respiratory Education project	Primary care: GPs	Audits performed at baseline, interim and post training. Data show patient understanding of their condition has increased. Recording of exacerbation has also increased.
20. Robotic surgery	Secondary Care	Robotic surgery is less invasive therefore patients recover faster with less blood loss, less need for pain killers and better outcomes e.g. blood transfusion rate for robotic surgery is 3% compared with 33% of traditional surgery.
21. Snakes and Ladders Project	Tertiary care with links to Secondary care and Primary Care	Role play enactment over an 8 month period stimulated debate about a wide range of issue, for example about bed management and led directly to service improvement.
22. Spotting the Sick Child	Primary Care	Change in the number of referrals to secondary care Year 1: 7% decrease in child referrals to secondary care compared with a 1% increase in the control area Year 2: 4% decrease in child referrals compared with the status quo in the control area.
23. Training the Trainers	Secondary Care: Across all specialities	Anecdotal Future accreditation of trainers

It is assumed by respondents that all the case studies led to an increase in knowledge and skills but demonstrating the impact of the CPD in terms of implementation of the learning is more difficult.

3.3. Theme 2: The barriers to undertaking CPD

Respondents talked about barriers to both undertaking CPD itself and to the implementation of learning from CPD. In terms of undertaking CPD, the four main barriers were perceived to be:

- Time/Workload
- Funding issues - opportunity cost in time out and / or financial cost of courses etc
- Protected time in consultant contracts – generous - less so / absent for staff grade etc
- Location of CPD
- Capacity to remove clinical staff from delivering service so they can train as a team

There was a general consensus amongst all respondents that the key issues which mitigated against successful CPD programmes were time pressures, workload and funding. Other potential barriers included the cost of CPD, the length of the course ("one day or half day courses are more popular") and geography (i.e. CPD area might extend over a large part of the country).

Time

Not surprisingly many respondents reported that time was a barrier both to undertaking the CPD itself but also in terms of finding the time to reflect and also to implement learning. Time and clinical pressures on time were cited in several of the case studies as the main barriers to undertaking CPD (Case Studies 12, 17, 18,19, 22, 23). Examples given of time as a barrier are as follows:

"Time – it's important that the participants, especially senior medical staff believe that the time provided for this project is productive and has value".(Consultant Psychiatrist, Case Study 18)

"This is a huge problem for GPs, no time to meet their colleagues and discuss....There is a conflict between service provision and finding time for learning" (PCT)

"Time – not only to attend the learning event but time to reflect". (PCT)

"Some doctors don't have enough time" (Acute Trust)

"There is no time for reflection – everyone is under pressure to deliver urgent clinical need". (Acute Trust)

The case studies based in general practice indicated that GPs find it particularly difficult to take time out of / from practice to undertake CPD as this can have a direct financial impact and consequences for patient care (Case Study 4, 17, 19) and it can be difficult to find and/or fund locum GPs to fill in.

Several Medical Directors noted that their Consultants 'would say' that time was a problem but that in reality they had plenty of time:

"Consultants often argue that they have insufficient time but all consultants in this Trust have 10 days study days a year - on top of that there is time to support professional development. Most people have 10 hours a week to support non-clinical activities including 4 hours of CPD a week." (Acute Trust)

For those trying to implement change in service delivery, the personal time commitment often appeared to be overwhelming and was often under-estimated when they set about the task. With hindsight the course leader of the medicines management training only became aware of the huge amount of time required to design and deliver the training on the scale required, during the delivery of the CPD. Similarly the GP behind the organisation of the new musculo-skeletal pathway in Sheffield found the time required to liaise with all the necessary organisations and achieve consensus on the new patient pathway was an 'enormous commitment'.

The commitment required by individuals to implement changes in service delivery or deliver innovation can be a serious deterrent to implement learning and individuals who do not have the support of the senior management of their Trust will struggle. One of the case studies highlights the role played by a single consultant in delivering technological innovation without the support of the Trust in the first instance.

Funding

One particular issue for GPs related to finance was the difficulty in not only funding but also finding a locum to attend a CPD session outside of the Practice. In some cases, this issue had been addressed by the educational provider bearing some of the costs (e.g. Pharmaceutical). Courses need to be well-designed and flexibly delivered, and one PCT medical director expressed concern about a "bean counter" culture of CPD, whereby CPD is measured by points rather than by application.

"If there is no accessible support people with give up, they will fall at the first hurdle. The training might be great but if there is no backup people will not be able to move on."

Some types of CPD require a whole clinical team to be trained. For example, new surgical techniques such as the Robotic Surgery impact on the whole clinical team, not just the surgeon and this needs to be taken into consideration when funding this type of CPD.

Finally more innovative types of CPD may require some funding upfront which can be difficult to acquire; for example funding for capital spending over and above participants' time. In one case study (no. 19) much of the CPD had to be self-funded.

Protected time in consultant and staff grade contracts

In several of the case studies, respondents cited the lack of allocated time in consultant and staff grade contracts or job plans for undertaking CPD. (Case study 23). Staff grade doctors reported that protected time was 'less generous'. Pressure of work can mean that doctors in theory have protected time but in practice have to cancel at the last minute, sometimes having to provide cover for other colleagues. (Case Study 1)

Location of CPD

Having to travel to another site to undertake CPD was regarded by some as a deterrent to undertaking CPD. A recipient of the management training offered by the Frontier

Programme (Case Study 10) said that one of the reasons they selected this provider was because the training was delivered at their site. However others felt that it was important that Consultants were able to undertake CPD overseas.

Capacity to remove clinical staff from delivering service so they can train as a team

 Some CPD is best taught to teams of clinicians rather than individuals but this can make the allocation of adequate time to the training very difficult in terms of freeing up a number of people simultananeously. This was particularly a problem in the COSBART case study (Case Study 3)

Other deterrents to undertaking CPD were: the timing of the CPD, and the length of the course. One respondent in a case study suggested that older doctors were less likely to engage in CPD delivered by e-learning. Another suggested that single-handed GPs were less likely to attend CPD events than other GPs.

3.4. Theme 3: The barriers to the implementation of CPD learning in practice.

There were four main topics emerging as the main topics to implementation of CPD as follows:

- Time
- Tick box mentality
- Idiosyncratic approach to CPD
- Opportunity to implement learning.

Time

Over and above finding the time to attend CPD events, respondents also cite time as a barrier to implementation. In particular, time is seen as a barrier to reflection which is regarded as part of the implementation process:

"There is no time for reflection – everyone is under pressure to deliver urgent clinical need". (Acute Trust)

"Time is a major pressure on Consultants in respect of applying learning from CPD activities in that as soon as they return from any length of study leave they are right back in the front line seeing patients and therefore don't always have the opportunity to apply what they have learnt. Many of the changes to patient care which arise from CPD activities require time for the doctor to discuss them with colleagues and managers etc. before they can be implemented – frequently this time just isn't available and therefore the service improvements just don't materialise." (Mental Health Trust)

"We all need time to reflect, particularly on unexpected events ....The problem is how do you record your thoughts/events that lead to learning on a busy day..... good ideas just float away on the wind" (Clinical Appraisal Lead, PCT)

The commitment required by individuals to implement changes in service delivery or deliver innovation can be a serious deterrent to implement learning and individuals who do not have the support of the senior management of their Trust will struggle. One of the case studies highlights the role played by a single consultant in delivering technological innovation without the support of the Trust in the first instance.

Tick box mentality

A number of respondents talked about the focus on collecting CPD points rather than on actually developing and implementing new skills. The Royal College of Obstetrics and Gynaecologists expressed concern that Trusts were not paying enough attention to CPD and noted that they tended to treat it as a 'tick box' activity. They also identified the dangers of this approach and described the main benefit of CPD as "enabling doctors to maintain their skills".

This was confirmed by a number of Trust respondents:

"CPD has not been tied into the appraisal process. It has been mainly a tick box to ensure you get enough points rather than looking at what CPD you actually did." (Large Acute Hospital, Medical Director)

A Medical Director of a PCT suggested that CPD in past has just been a "tick box". He went on to suggest this had been overcome by using the formative elements of the appraisal; the formative stage being to identify their CPD and develop a good PDP. This viewpoint was supported by the RCGP:

"Good CPD and PDP hinges on an appraisal with a good appraiser who will challenge you leading to more challenging CPD rather than just tick box CPD." (RCGP)

 The main groups of doctors who had difficulty in respect of achieving adequate CPD were "locums, those in private practice and those in very specialised areas of practice".

 Another Trust (Medical Director, Mental Health) thought that the main barrier to implementing learning from CPD was the *"organisation resistance to new ideas – people come back from events full of enthusiasm which, if not identified and nurtured quickly i.e. within a week, can soon be deflated"*. In response to this, the Trust has identified someone to act as innovations lead to fulfil this role of nurturing and develop an innovations network within the Trust.

Another Trust reported that *"Many Trusts have very risk averse cultures which don't encourage innovation in terms of approaches to treatment"* (Assistant Medical Director for Continuing Professional Development, Mental Health Trust) and thought that the key to overcoming such barriers was a better relationship between the Trust Executives and its staff. However, an organisation will only change when there is need, vision and urgency to do so.

Idiosyncratic approach to CPD

Several respondents told us that CPD was entirely a matter for individuals and that Trust or organisational objectives did not play a role. This view tended to come mostly from Secondary Care. This was often combined with a view that CPD was not linked to the appraisal process. Whilst individual doctors in these circumstances may well have successfully have implemented their learning, CPD activity in isolation means that it may be difficult for this to be documented and less likely that line managers would have a role in challenging individual doctors to demonstrate their implementation of learning.

"It is very much up to individual doctors to do what CPD they want." (Large Acute Trust)

"By and large people choose the CPD they want to do based on what they fancy.

CPD has not been tied into the appraisal process." (Medical Director, Large Acute Trust)

'I think there can be an organisational culture issue. People don't join the dots. They don't appreciate that CPD should be helping them professionally rather than just something that they enjoy. We need to ask what they can bring back from their learning as if they come back saying they knew it all already then why did they go.' (Medical Director, Integrated Acute and Community Trust)

Opportunity to implement learning

Not all CPD can be implemented at will on completion. Some CPD relates to education about rare clinical conditions or scenarios which doctors may only encounter once every few years. For example, the COSBART training delivers training for Consultant Anaesthetists in rare emergency scenarios that they may encounter in an anaesthetic emergency in theatre such as hypoxia, drug reactions, and blood loss. These are rare occurrences in theatre and so there is no guarantee that participants will get an opportunity to implement their learning. Similarly the case study featuring dementia training for GPs is considered necessary because on average a GP might only see four or five patients with dementia per year which makes it difficult to build up any expertise in the area. Following training, a GP may also wait some time before they see a relevant patient.

A similar problem exists with CPD for leadership. Both the leadership case studies noted that not all delegates attending leadership training are in a position where they can exercise their new skills and they may have to wait some time for the opportunity to arise. Whilst opportunities to manage others can be created this often depends on the support of others within the organisation. This makes measuring the implementation of CPD in leadership and management a difficult exercise.

3.5. Theme 4: Facilitators of the implementation of CPD

A wide range of facilitators were identified to support the implementation of CPD:

- CPD part of bigger process i.e. tied into PDPs and appraisals
- Strategically driven CPD
- The importance of reflection
- Leadership and the Role of Royal Colleges
- Able to test or practice new knowledge or skills without fear of exposure.
- Role of Deaneries
- Case based /audit
- Benchmarking
- Financial incentives to implement learning

CPD linked to appraisals and PDPs

For many of the Trusts interviewed as part of this project, CPD took place in isolation to other activities and was not linked to PDPs or the appraisal process. Those Trusts which had integrated the process were in a better position to demonstrate implementation of CPD - that is not to say that CPD does not have an impact in those Trusts which do not link CPD to the appraisal process, but rather that implementation is very much left up to the individual to initiate. It also means that at an organisational level there is little awareness of what CPD has taken place and even less idea as to whether it has been implemented.

In some of the Trusts in which CPD was linked into the appraisal process this was not as robustly as it might be. Some Trusts were able to make the link on paper but did not as yet have the electronic systems they needed to manage the process online. For example:

"At the moment we don't have a process to capture information on CPD – there is no central CPD database for example." (Large acute Trust)

Some of the case studies demonstrated a close relationship between the CPD undertaken and the appraisal process. For the Frontier Programme delivering CPD to Staff grades and associate specialists, all applicants have to demonstrate that the CPD they wish to undertake is reflected in their Personal Development Plans and also have to show how the CPD will meet organisational objectives as well as their own personal ones.

A representative of a Health Board in Wales noted that they had such an electronic system in primary care but not as yet in secondary care. The system had a quality assurance component which picks up detail in the Personal Development Plan [PDP] at later stages. The system allows the Health Board to identify patterns in terms of training needs to inform the delivery of local training.

The ability to aggregate appraisal data was also noted by another Welsh Health Board:

"The CPD group gets quarterly aggregated data on needs coming out of the appraisal process. Data is [sic] also captured by the doctor online and is reviewed at the appraisal interview".

The same Health Board had also issued guidance on demonstrating impact for use by appraisers. The guidance was informed by the Welsh Deanery which provided one day

workshops on how to look at the impact of CPD using audit and reflective practice.   A representative of the Welsh Deanery confirmed that the same office was responsible for both CPD and appraisal and said that they encouraged a strong culture of challenge in the appraisal. The Welsh Deanery also conducts quality assurance of appraisals and reviews the challenge that has been introduced in the process. The same emphasis on demonstrating the implementation of CPD was not evident in the Scottish data.

Strategically driven CPD

The previous section noted that the individual responsibility for CPD can act as a barrier to implementation. The other end of the spectrum is strategically driven CPD driven by organisations such as the employing Trust, PCT, Health Board or a Royal College (See Case Studies 3,4,5,6,8,9,11,12,13,14, 1922). Trusts have traditionally driven mandatory CPD such as compliance issues around child protection and Do Not Resuscitate policies.   Indeed in some Trusts the delivery of mandatory CPD has been their sole interest in CPD. However, there does seem to be a gradual shift with Trusts taking a greater interest in the identification and delivery of CPD:

"CPD has long been seen as personal to the individual Doctor. There is now a move towards an individual Doctors CPD activities being aligned with the Trusts objectives – this has proved to be a steep learning curve in terms of cultural change.

The Trust took on responsibility for Community Services in April 2011 and since then has been in a process of reorganisation which has led to opportunities for CPD activities involving Doctors from both the Mental Health and Community Services i.e. CAMS.

The line between purely clinical CPD and management development is becoming blurred as more clinicians are becoming involved in leading the development of services i.e. Clinical Commissioning Groups." (Medical Director,Community Trust)

"There has been a fundamental change in how CPD activities are viewed. In the past a Consultant undertook CPD activities which were of personal interest to him/her. Following on from that the Consultant might decide to develop a service in which they could use their special interest in which they had undertaken CPD. Nowadays there is a much greater emphasis in service development being driven by the Trusts objectives, the divisions plans to achieve those objectives and the Consultants contribution towards the achievement of those plans etc." (Mental Health Trust).

CPD which is part of a larger strategically driven project is more likely to be implemented. For example, the Dementia Education Case Study was funded by South West SHA and driven locally by a multi-disciplinary team including the PCT, Consultant Psychiatrists together with representatives from academia and the voluntary sector. Their view was that:

"The collaborative approach has paid dividends for us, getting the right people and discussing the training, what is the best way of doing this, comes back to our local strategy". (GP Facilitator, PCT).

Similarly the Do Not Resuscitate Case Study was stimulated by the East of England SHA and driven locally by the PCT but involved close co-operation from the local acute Trust and the local ambulance service.

The importance of reflection

One key theme emerging from the interviews was the importance on reflection and how appraisal/revalidation had brought this to the forefront of CPD. Several respondents reported that reflection was particularly difficult for older learners but was becoming routine for new graduates. Most respondents put a great deal of faith in reflective processes as being key to the successful implantation of improvements to care, although there was a large variation in this belief that this reflection could make a difference to care. For example, responses varied from *"well, it's really a nurse's thing"* or *"We don't use reflective practice for doctors – nurses use this approach but not doctors"* (Large acute Trust) to being a *"core activity"* in general practice CPD.

Several respondents suggested that reflection did not need to be a formal activity and was considered something that took place anyway, sometimes at an unconscious level:

"There is no time for reflection – everyone is under pressure to deliver urgent clinical need. Reflection is almost an alien word. Consultants may do it anyway but they don't call it that." (Secondary Care)

Respondents discussed both the time implications of reflection and the way that a forced activity might undermine something that all doctors do anyway at an unconscious level.

"We all need time to reflect, particularly on unexpected events on a busy day. The problem is how do you record your thoughts....tried to do this with a variety of techniques e.g. electronic spreadsheets, post it pads". (PCT)

Some respondents called for a greater focus on reflection. *"There has to be a shift from providing evidence of attending CPD to providing evidence of reflection".* (Large acute Trust)

Many respondents noted older doctors found it harder to reflect whereas younger doctors were more familiar with the concept. A respondent responsible for professional support from a Deanery made some interesting observations about older doctors struggling with CPD:

"I work with doctors in difficulty and often find that these doctors coming to me have problems understanding how CPD works – they bring their certificate but don't produce any reflection. Especially the older doctors who are not used to working in this way. I encourage them to reflect. I think their lack of reflection is often why they get into difficulties. Lots of the doctors that I see trained when medical education was less sophisticated. The younger doctors are now trained to think and practice more reflectively." (Deanery)

Additional support is required for those people (e.g. older doctors) who do find reflection and learning harder, particularly when they return to their practices. The impact of different ways of including reflection in the delivery of CPD was also recognised as an important component of any CPD package. Following an online CPD module with follow-up, one key issue identified was the importance of the interaction and the opportunity of GPs to meet their local

specialist clinicians. This personal aspect of CPD was highlighted by a number of respondents who also pointed out the importance of having a good speaker providing the opportunity for some networking. Again, reflection was emphasised as an essential component to digest what had been learnt at a particularly CPD session and this, of course, was dependent on there being sufficient time to do this. The consultant contract contains up to 2.5 SPAs per week which can be used for CPD, although some Trusts had negotiated this amount of time down to 1.5 SPAs per week. In addition, consultant colleagues had a wide range of budgets available to support their learning, although this had also been reduced recently. There was no such provision for GPs who have no protected time for CPD and have to fund their own learning

Other respondents emphasised case-based learning coupled with audit and the importance of cascading knowledge through an organisation to maintain enthusiasm and commitment to the new learning One respondent said that where reflection is left entirely up to the individual it is haphazard and variable. Most Trusts noted that without support from the employing organisation CPD is unlikely to be long-lasting and helpful and that support to benefit from CPD is required at all levels including the notion of support networks.

One of the case studies (Dementia Education case Study no.5) is an excellent example of how a little support with reflection in terms of providing a supporting structure can aid the process and so aid the implementation of CPD:

"It is essential that reflective learning forms are available on the Bath GP Education website, which prompt GPs to not only think about what they learnt but how to implement their learning in their day-to-day practice, as well as a prompt to feedback their learning to colleagues in practice, either formally or informally to ensure the information cascades down." (GP Course Organiser)

Leadership and the Role of the Royal Colleges

Although the educational materials produced by all the Royal Colleges (particularly the RCOG, RCPCH and the RCGP) was commended as excellent by many respondents, it was the RCGP that had made most progress towards completing the learning cycle by supporting the implementation of learning in Practice. For their annual appraisal GPs are expected to earn 250 points over a five year cycle. The RCGP has developed a new system which does not involve counting time but instead looks at challenge and impact. GPs are asked to demonstrate the difference that their learning has made to their professional behaviour and the final system, which is linked to appraisal, still has a time element to it i.e. one hour's worth of activity equates to one credit. However, if a GP can demonstrate impact he or she can get double the number of credits and the system is designed to demonstrate that their CPD learning has been implemented in Practice. The evidence required may include case scenarios, event analysis or audit. The RCGP also offers peer review of completed audits to members for inclusion in their Personal Development Plans. In addition, they may simply share a new protocol with their Practice, this new system is being used for appraisal. However, this scheme is not compulsory nor is it an easy option or as straightforward as one might think.

"Good CPD and a good PDP hinges on an appraisal with a good appraiser who will challenge you leading to more challenging CPD rather than just 'tick box' CPD". (RCGP)

The RCGP scheme allows for reflection based credits and it is no longer good enough to get a certificate of attendance. However despite these great efforts at getting learning into practice, the evidence that CPD has had a real impact on GPs practice and performance is based primarily on self report and remains generally anecdotal.

Again, another Foundation Trust thought that for CPD to be effective it had to be properly planned and linked with a PDP and service delivery.

"Much CPD fails to be implemented because it's brought back by the individual consultant to the 'wrong setting' or at the 'wrong time' and then isn't implemented locally." (Consultant Child and Adolescent Psychiatrist, Mental Health Trust)

The importance of CPD leadership was identified by a Scottish Health Board [where there is already a joint vision between managers/policy makers and medics] as crucial to success – CPD ideas need to be supported to make them happen. Barriers to successful CPD, though, are primarily cultural; e.g. conservatism, narrowness of thought and entrenched professional conservatism, and that often people are not always well-placed in a hierarchy to put forward a case for change. These issues were identified independently by another Scottish Health Board who talked about changing attitudes towards CPD and the "resistance" from older doctors. Other Health Boards thought that the process of working together in a group was particularly valuable; the crucial importance was learning with peers rather than *"experts who come and tell you things"* but the content needed to be of interest and delivered in 'bite size' chunks. One integrated Trust (primary and secondary care) also identified the organisational culture as being an important issue in the success or otherwise of CPD. They thought that their doctors did not always appreciate that CPD should be helping them professionally rather than just being something that they enjoyed. To address this they rewarded and encouraged people whenever they share and bring learning back from a CPD event – they have a rather *"cheesy clinician of the month award and a newsletter that emphasises how we value people doing these things".*

The Royal College of Anaesthetists promoted approaches to CPD which do not have significant costs e.g. shadowing colleagues but in addition, they have a significant eLearning platform (e-learning for anaesthetists) and publishes a CPD journal as part of the British Journal of Anaesthetics.

Role of Deaneries

Deaneries were responsible for four of the 23 case studies (Case Studies 7,10, 15 and 16) and they have an important role in facilitating the implementation of CPD. They are currently responsible for funding and delivering CPD to Staff Grades, Specialty Doctors and Associate Specialists (SASG) and they also provide leadership programmes for doctors in both Primary and Secondary Care across the country. In both cases the Deaneries worked hard to encourage the reflection process and the implementation of programmes for SASG. The Frontier Programme based at the London Deanery, for example, which is responsible for

delivering CPD to SASG doctors, reported that applicants for their funding have to demonstrate that the CPD they wish to undertake is noted in their personal development plans. On completion of the CPD, all recipients are asked to write a reflective account of their training and state how they CPD will impact on their practice, their organisation and on patient care. Recipients of funding are followed up at 6 months after completion of training. In delivering leadership programmes, the Deaneries usually work closely with those undertaking the courses to support them in implementing service improvement and change management. The work undertaken by the Deaneries facilitates good practice by demonstrating how CPD fits into the learning cycle and supports large numbers of doctors of this process.

Revalidation

There was a widely held opinion that revalidation would be an incentive for doctors to complete the entire learning cycle and produce evidence of the impact of their learning; this was true for both primary and secondary care as well as the Royal Colleges.

'Revalidation will make a difference – initially the reaction will be negative but eventually people will see the benefits of it.' (Medical Director, PCT)

'Doctors will be expected to use a reflective learning approach and look at how CPD has changed their practice or how it has helped them to identify services that need to be developed etc. This has been driven by the revalidation requirements' (Director of Medical Education, Health Board in Northern Ireland)

'There are a small minority of the 5% sample who don't respond to requests for evidence of CPD activities and are uncooperative. It is hoped that revalidation will have a positive impact on this minority' (Royal College of Paediatricians)

The impending influence of revalidation was also identified in the cases studies as a facilitator of the impact of CPD, for example:

'With the introduction of GP appraisals and revalidation BASD recognised that locums and sessional GPs need some extra support to fulfil all the criteria that are required for a GP to gain revalidation' (Course Leader, Bristol Association of Sessional Doctors (BASD), Case Study 17)

Essential Knowledge Updates provided by the RCGP have been developed to contribute, in due course, as part of the managed CPD scheme to the provision of evidence of a GP's learning and application in their personal portfolio for revalidation purposes. (Case Study 8)

Pathologists also use the External Quality Assessment Schemes to inform their appraisals and expect it to also inform their revalidation in the future.(Case Study9)

Case based audit

Several of the case studies employed audit to measure the impact of their CPD. Some of these were large scale audits to identify change across a number of doctors. Examples of case studies which used an audit approach were:

- Essential Knowledge Updates: RCGP (Case Study 8)
- Medical management (Case Study 11)
- Musculo-skeletal pathway (Case Study14)
- Coeliac Disease (Case Study 2)
- Do Not Resuscitate Training (Case Study 6)
- Mental Capacity Act (Case Study 13)
- Respiratory Education project (Case Study 19).

Some case studies were able to conduct audits pre and post the CPD and some were able to also conduct a follow up audit which allowed time for the implementation of skills. The following case studies used follow up audits:

- Advanced Life Support Group administered a survey to all participants 6 months after completion of the training. (case Study 1)
- Coeliac Prescribing Guidance case study used a pre and post audit supplemented with a follow up audit to monitor prescribing behaviour. (Case Study 2)
- Do Not Resuscitate Training used continuous audit data to monitor the number of Do Not Resuscitate Cardiopulmonary Resuscitation orders made over time which allows a comparison to be made before and after the delivery of the CPD. (Case Study 6)
- Essential Knowledge Updates provided by the RCGP requires participants to complete an online survey with 50 questions – this is an open book test. Participants are also asked to give feedback on the programme including giving feedback on what they would do differently having completed the Knowledge Challenge. (Case Study 8)
- Gwent Respiratory Education Project conducted baseline, interim and final audits in each of 38 practices using POINTS Audit Software. (Case Study 19)

Ability to practice or test new knowledge without fear of exposure

The importance of the anonymisation of learning achievement was a common theme emerging from the case studies and it took a number of forms. For instance, in both the Essential Knowledge Updates programme run by the RCGP and the External Quality Assessment Scheme run for Pathologists results are fed back anonymously but benchmarked to their peers. In the pathology schemes even where the candidate receives sub-standard scores and is monitored in terms of future progress, the identity of the candidate is not disclosed to anyone - even those running the scheme. In another case

study the participants in the CPD were concerned about showing ''weakness'' in a multi-disciplinary setting and so the single disciplinary approach to CPD was retained.

Benchmarking

The ability to compare and benchmark those who have undertaken the CPD is perceived to be a motivating force in implementing their learning. The benchmarking may be at individual level or it may be broader at practice and ward level. However the Medicines management case study noted that making comparisons at an individual level was more meaningful and useful than data comparisons at ward level.

The RCGP administers a Knowledge test six months after the completion of CPD and the results for each participant are benchmarked against their peers with over 8,000 GPs participating in each six monthly session.

The Gwent Respiratory Education Project used the audit data to allow GPs at each practice to review their performance in relation to others and to then plan appropriate actions as a result.   They found that 'evaluating patient outcomes as part of the programme was a real driver and motivator'. Similarly the 'Spotting the Sick Child' project identified the importance of sharing success in order to generate peer pressure amongst GPs.

Financial Incentivisation of GPs

Just one case study referred to the use of financial incentives in primary care (See Spotting the Sick Child). Financial incentives are used widely in primary care to ensure widespread implementation usually in the form of payment for enhanced services.

3.6. Theme 5: Overcoming barriers to CPD and lessons learnt

The data on overcoming barriers and lessons learnt have been condensed into one theme. Seven main sub themes were identified which are described below:

Time and effort required

With hindsight many respondents admitted that they had under-estimated the amount of time and effort required to implement their learning, especially if this involved service improvement. (Case Studies 3, 11 and 14). In many cases this required additional secretarial and administrative support which had not always been allowed for. Respondents also noted that there was insufficient protected time to discuss with peers, plan implementation and disseminate or cascade learning with the wider team. Some respondents noted that with better planning they could have delegated more to others rather than trying to do everything themselves.

The need for ongoing support over and above training

The findings emerging from the case studies suggest that it can be difficult to implement learning from CPD in isolation. A common theme emerging from the case studies was the need for ongoing support for doctors who were expected to implement their learning - especially where this was part of a wider service change initiative. For example, the medicines management CPD in an Acute Trust initially had a problem with 'stragglers' who did not attend the training and older doctors who could not see the point of the training. Rather than simply circulating audit data on prescribing, the Trust set up a taskforce with multi-disciplinary teams (with a consultant in each team) who undertook visits to wards to support compliance and provide advice on improvement. They also issued weekly messages to Trust employees.

Support from individuals was crucial to successful implementation in many projects. For example in the Do Not Resuscitate project, a Palliative Care Consultant and End of Life Facilitator were available to give individual support to GPs and others.

In the Robotic Surgery project mentors were used to support learners and their role was considered pivotal. However they also noted that individuals should not move from the role of trainee to mentor too quickly and they advised that individuals require considerable experience themselves before taking on the role of mentor.

The development of a website was considered essential to the success of the musculoskeletal pathway project. An all encompassing website was developed to support behaviour change amongst GPs which included all the information they needed including patient information leaflets, assessment tools, educational material and referrals forms. The website also contains a section for patients where they can complete the assessment tools for themselves. The website played a vital role in helping the many partners in the project focus minds and achieve consensus on the detail of the pathway.

DVDs were the outputs from two of the case studies. The Regional Course for the Royal College of Psychiatry Exams has been produced as a DVD which is now sold widely through the UK and abroad. The Snakes and Ladders Project run at Great Ormond Street has led to both a book and a DVD.

Using routinely collected data to measure outcomes

The Medicines Management case study found that it was relatively easy to adapt or design routine data collection tools which would be used anyway to collect the data required to audit the implementation of learning rather than trying to set up some entirely new form of data collection which participants may resist. Secondly they found that the unit of analysis in the audit needs to be at the level of individual doctor rather than a higher level such as ward or practice. Benchmarking is a useful tool motivating changes in practice but it needs to be at an individual doctor level if further support is to be given.

'The drug chart was re-designed to act as a prompt to implement actions which had been covered by the CPD'. (Audit Manager, Acute Trust, Case Study 11)

Other respondents also noted the benefit of using existing data sources to monitor the impact of CPD:

"We have done lots of work on COPD measuring the impact using audit plus – it's an automated audit gathering anonymised patient record data from GPs records. Our audit shows that the training we have done in this area has had an impact and that the quality of care for COPD has improved." (Health Board in Wales)

Simplicity

Another theme that emerged repeatedly from the case studies and interviews was the need for simplicity or as one course organiser put it *'doing simple things well'* (Gwent Respiratory Education Project). In the Do Not Resuscitate CPD case study one of the lessons learnt in implementing the CPD was that the process for sharing information between services had to be kept as simple as possible because anything complicated would hinder compliance. Similarly the COSBART case study noted that "*Simplicity and repetition is preferable to complexity.*"

The need for simplicity extended the evaluation of outcomes. North Yorkshire PCT noted that *"simple audits are a great way of measuring outcomes as a result of CPD. We encourage GPs to do simple one criterion audits rather than trying to save the world. They can get a real buzz from this – leading onto gold standard double cycle audits"*.

Learning with peers

Learning with peers rather than with expert was deemed to be of crucial importance in the Practice based small group learning case study. The course leader considered this approach led to a different kind of learning experience with deep learning which in turn facilitated implementation of learning.

Targeting of CPD

A number of case studies (e.g. Dementia Education, Do Not Resuscitate) noted that it was 'all too easy' to set up well attended CPD events. However, the delegates were in many cases likely to be those doctors with a particular interest in topic matter and that what really mattered was reaching those who have no interest in the subject matter as these are the people that might benefit the most from the CPD.   This might mean that special events have to be held for those doctors who do not attend the initial round of CPD or other ways found of delivering the CPD to them.

Winning Hearts and Minds

A number of the case studies talked about the importance of trying to 'win hearts and minds' when attempting to change the culture of practice with a CPD initiative. The case study on CPD for the Mental Capacity Act suggested that it is better to refrain from being too

prescriptive or being too driven by targets. CPD aimed at changing behaviour needs to be 'owned' by the doctors undertaking it so they do not feel that they are being forced to change their practice.

It was also noted that doctors and other professionals affected by the implementation of CPD need additional time and support to process the changes and think about how they could be implemented in practice.

"we had to constantly stop and reflect on how it was being implemented to ensure that we were not just delivering a training programme but also a process through which all affected could be involved and supported to make the necessary changes in their everyday practice in a way that was acceptable to them". (Course leader, Community Services Provider)

3.7. Theme 6: Trust perspectives of CPD

There is huge variation in the attitude of senior Trust management towards CPD with some Trusts 'directing' the CPD and others with a more 'laissez faire' attitude – large differences between primary and secondary care organisations were apparent – a major driver for some of these differences in the way that CPD is organised and delivered in the two sectors was 'protected time' [for consultants] and funding arrangements [business approaches, role of pharmaceutical industry and GPs having to pay for their own locums etc]. In addition there was a wide variation in views where CPD should take place.

 For example, a key issue which was highlighted by the Royal College of Surgeons was the importance of surgeons being able to attend international events to learn about how services and procedures are undertaken in different countries, although, "consideration needed to be given to whether or not such procedures would be ethically acceptable in the UK". The solution proposed was more time for surgeons to attend such international events.

One Deanery had a rather broader definition of CPD that "*CPD goes on all the time in professional conversations. Consultants teaching has a profound impact on the process of learning*". This had an impact on where the Deanery thought that CPD should take place. The key to successful CPD was structure and the creation of the right environment to ensure that CPD had a high status, was valued and accountable. The importance of everybody needing to 'buy in' was also emphasised by a number of Trusts.

More than one Acute Trust identified the lack of implementation as the result of poor management and poor leadership. No follow through and a lack of evaluation were described as the major barriers to effective CPD and there was some pessimism about the possibilities of changing the current learning culture: e.g*. "There are pockets of excellence but most won't change their ways with revalidation".* (HR Director, Acute Trust)

Other Trusts disagreed with this and thought that revalidation would make a big difference: *"initially the reaction will be negative but eventually people will see the benefits of it. Doctors will need to demonstrate personal change; this is a simple move but very powerful and this is to be welcomed"* (Clinical Appraisal Lead, PCT).

Respondents at Trust level (mainly Medical Directors and Medical Education leads) were asked about the impact of CPD on practice in terms of the change engendered in individual

doctors, for example, in the way that care was provided by doctors/teams and improvement in patient/service outcomes.   There was a clear consensus amongst respondents at Trust level that CPD did have an effect not only on individual doctors but also in the way that care was provided to patients. However respondents at this level of the organisation struggled to produce evidence to support this belief when asked. Typical responses were as follows:

"I think it does but it's an act of faith." (Deanery)

"hope it has an impact otherwise I wouldn't be doing this job"

"take it as given" (PCT)

"I believe that CPD has an impact on patients and practice".

"I know that as a result of CPD, doctors have better skills and are more up to date but that isn't the same as looking at the impact on practice and performance." (Health Board, Scotland)

One respondent described CPD as *"70% affirming current practice, 20% gaining new ideas and 10% identifying new ideas that can inform/change their practice"* (Director of medical Education, Integrated Health and Care Trust in Northern Ireland) whilst another respondent described CPD as having three levels of impact on an organisation: organisational, individual and group.

Trusts identified the main influences on the impact of CPD as being:

- Maintaining the status quo
- Lack of evidence of impact related to cost of evaluation & difficulty in measuring impact
- Role of Primary Care
- Role of appraisal/revalidation
- Focus of Acute Trusts on technical skills.

Maintaining the status quo

In some Trusts there was a belief that CPD merely enabled doctors to maintain their existing standards and keep up to date. In one Large Trust providing tertiary services, the view of the Medical Director was that CPD merely helping doctors maintain their current standards rather than leading to improvements. Conversely he believed that innovation in the Trust was driven by the doctors themselves, not by CPD. The Royal College of Obstetricians and Gynaecologists supported this viewpoint:

"The major benefit of CPD was seen as enabling doctors to maintain their skills. In respect of improvements in patient care, CPD was perceived as not making anything worse but maintaining the status quo or hopefully improving a doctor's performance".

Lack of Evidence for impact of CPD

Many respondents stated that although they believed that CPD must intuitively have a beneficial impact, they also commented on the lack of evidence for its effectiveness:

"Proving this is a magic bullet" (Medical Director, PCT)

"We don't measure this" (PCT)

"We need better ways of demonstrating this as there is a lack of hard evidence" (Mental health Trust)

"We don't attempt to measure this. We make no attempt to link CPD with their performance" (Secondary Care)

"It is difficult to prove evidence of this, could not do this" (Secondary Care)

The reasons for the lack of evidence for the effectiveness of CPD included the difficulties of demonstrating an impact but, in particular, the cost of such a necessarily robust evaluation on the CPD programme. Formal evaluation of CPD is rare, although doctors in primary care are encouraged to use audits to measure the implementation of their CPD. Just one of the case studies proposed using an experimental approach with a control area to measure the impact of the CPD (Spotting the Sick Child in a Primary Care setting).

One primary care respondent said that they asked CPD participants to undertake "small audits" to measure change, although others viewed CPD as *"a methodology for people to keep up to date"* (Director of Medical Education, Secondary Care). The importance of planning CPD learning was emphasized, with one respondent reporting *"a link between those who plan their learning and those who achieve real change as a result of their CPD"* (Clinical Appraisal Lead, PCT).

Respondents also acknowledged the incremental process of changing practice: *'The other thing to realise is that change is often incremental, and that we don't realise how much we've changed our practice over a period of time until we reflect back, but this will have changed patient and service outcomes.*(Medical Director, PCT)

Role of Primary Care

Most Trusts we spoke with had no way of measuring impact or even collecting feedback. The exception to this was General Practice. The RCGP, for example, recommends a system whereby the number of CPD 'points' may be doubled up to a maximum of 30 of the required 50 points per annum awarded if the individual can demonstrate that they have implemented their learning in practice. As a consequence GPs are motivated to undertake small scale audits and write reflectively about the application of knowledge to practice in order to demonstrate implementation/ impact.

"Simple audits are a great way of measuring outcomes as a result of CPD. We encourage GPs to do simple one criterion audits rather than trying to 'save the world'." (PCT)

Several respondents said that they invested in training needs assessment but very rarely completed the learning cycle by measuring the outcomes of the subsequent training.

Role of appraisal / revalidation

A great deal of hope was invested in the linking of CPD with the appraisal cycle and in the immediate future the potential links with revalidation. Expectations for revalidation were very high and many respondents were assuming that the revalidation process would bring the organisation greater control over CPD and tie into other procedures such as appraisals and Personal Development Plans [PDPs].

"Revalidation, perhaps, offers the best hope for an impact on patient care of CPD".

However, one medical Director of a large Teaching Hospital did not have high hopes for revalidation in respect of CPD:

"Don't think we can change a culture, there are pockets of excellence, but most won't change their ways with revalidation." (Acute Hospital)

Respondents in secondary care were most likely to make statements about how they expected revalidation to link up CPD with the appraisal process in the future and therefore make it easier to assess both the implementation and the impact of CPD. It was rare for a representative of a Trust in secondary care to state that their CPD activity was linked to their appraisal process or that it was recorded centrally in anyway. By contrast most representatives of Primary Care Trusts said that their CPD activity was already linked into the appraisal process which immediately gave them a clear overview of the CPD activity in their area and the extent to which it was being implemented.

Aligning individual objectives of CPD with those of the Trust was a desired aim of a number of the Trust respondents – however, this again was more wishful thinking than reality with one Trust director pointing out that

"we make no attempt to link CPD with their performance and the consultants were able to chose the CPD they wanted to do based on what they fancy" (Medical Director, Acute Trust)*.*

Strategic input from an organisational perspective into the type of CPD undertaken was most common in primary care and more likely to be absent in secondary care.

Focus of acute trusts on 'technical skills'

Other comments from Acute Trusts were that the *"doctors were really only interested in doing CPD in technical stuff. latest widgets, laser techniques etc. They are not interested in such soft areas like communication skills'.*

"CPD does not cover balanced skills." (Acute Trust)

Much generic CPD was thought to be more suitable for multidisciplinary training, although there was very little evidence in these interviews of such training taking place. No claims for effectiveness were made for the CPD delivered as part of mandatory training in secondary care; it was considered to be almost a separate category. In some cases mandatory training was seen as detracting from 'real' CPD and considered a waste of resources and time.

3.8. Theme 7: Cultural differences between how CPD is organised in primary care and secondary care

The research found cultural differences between primary and secondary care in terms of:

The extent to which CPD is linked to other PDPs or appraisal

In primary care CPD seems to be more likely to be part of a learning cycle where the need for the CPD has been identified in the PDP and the appraisal the following year will follow up on whether the CPD was actually undertaken and also whether it has been implemented in Practice. In many of the secondary Trusts included in the study, CPD took place in a vacuum and was neither linked to organisational strategic objectives nor appraisals. Where CPD takes place in isolation there is a greater scope for it to be either not implemented or for a lack of documentation about its implementation.

The extent to which CPD is selected according to the needs of an individual vs a vs the strategic needs of the organisation/community

Where CPD was centrally organised and/or delivered in secondary care, it tended to be in relation to mandatory training only. This was generally not regarded as ''true'' CPD by many respondents. By contrast, in primary care, there appeared to be more CPD delivered as part of a strategically based need on behalf of either the PCT or the community. Doctors in primary care are more likely to partake of CPD which meets the needs of the employing organisation, or the wider community. However there are some examples of CPD which impacts on the wider community and which follows patient pathways across primary and secondary care such as the Do Not Resuscitate training delivered in South Essex which was delivered to GPs, community staff, ambulance staff and hospital employees.

The extent to which reflection is undertaken

All the Royal Colleges represented in this study said that they supported reflection but the degree to which they actively support the process and recording of reflection varied between Colleges. For instance the Royal College of Paediatricians strongly encourages their members to use reflective practice and encourages them with College systems to record it but the quality of the recording of reflection is limited and difficult to assess. It is hoped that the amount of reflection undertaken will increase through appraisals.

The type of CPD e.g. multi-disciplinary

It was clear in the interviews that GPs were more likely to be participating in multi-disciplinary CPD than their secondary care colleagues. Doctors in secondary care appeared to be resistant to the concept of multi-disciplinary learning even where the activity they were being trained for required the participation of other professionals. There was an anxiety that they could not show a lack of knowledge in front of other professional groups. This concern was

not raised by doctors in primary care. The following comment was typical of some Trusts in Secondary Care:

 "We don't do that much work (CPD) with multi professional teams. We have tried to do this but I have faced resistance, both from doctors and nurses in making this happen. There has not been much sharing of knowledge." (Large Acute Trust)

Secondary care – tick box mentality 'as long as enough points'.

The findings collated here would suggest that doctors based in primary care are more ready for revalidation than their colleagues in secondary care. The following quote illustrates the expectations of GPs in relation to their CPD.

"Not necessarily expected but GPs should demonstrate impact – take back what they have learned to practice. Is there any point in going to CPD events if there is no impact? Gone are the days when GPs listened, and thought there's a point earned. But we have to make education relevant and interesting." (Medical Director PCT)

From the evidence collected it would appear than doctors in many large acute Trusts are not used to their CPD being linked to their PDPs or their appraisals. Culturally doctors in secondary care are not expected to document how they may have implemented their learning nor to record evidence of reflection. This means that the requirements for revalidation may be quite challenging initially for many doctors based in secondary care.

4. Discussion/Review and Summary of Findings

How does doctors' participation in CPD affect their practice and performance?

Whilst there is an absolute belief in most cases that Doctors' participation in CPD does improve practice and performance, respondents were hard pushed to give examples of this. However the case studies attached do provide plenty of examples where CPD is seen to improve practice and performance, for example:

- The CPD provided by the Advanced Life Support Group has been put into practice by 86% of participants who attended the Advanced Paediatric Life Support course and 100% of those who attended the Managing Obstetric Emergencies and Trauma CPD said they had put the skills into practice.

- The Dementia Education Case Study shows how GPs are changing their approach to patients with dementia on completing the CPD programme.

- The respiratory Education Project for GPs shows how GPs have communicated better with their patients and improved their monitoring of respiratory symptoms.

For some respondents however, there was a clear belief that CPD only enabled doctors to maintain the status quo rather than leading to an improvement in clinical care per se.

How does participation in CPD contribute to improvements in patient or service outcomes?

There are a number of examples of CPD contributing directly to patient or service outcomes but they are difficult to identify unless they are part of a wider service improvement project. Case studies which demonstrate clear examples of patient or service improvement which are attributable to CPD are as follows:

- The Musculo-skeletal pathway programme has led to 95% compliance with a new referral pathway, a 20% drop in referrals for spinal pain over two years and a surgical conversion rate increasing from 20% to 50%.

- Do Not Resuscitate (DNACPR) Training has successfully implemented information sharing in relation to Do Not Resuscitate Orders across Primary, Community and Secondary services in South Essex. Doctors are now more confident to make DNACPR orders and the numbers in the community have increased from 99 in the last 9 months of 2011 to 230 in the first 6 months of 2012.

- The Practice Leaders Programme is supporting a wide range of service improvements including improving patient access through physical redesign, redesign of chronic disease management systems, and improved information for and communication with, patients.

- Mental Capacity Act Training has led to a significant increase in activity recorded within 2011/2012 since the implementation of the training action plan in October 2011. Mental Capacity Act activity rose by 194.52**%** and Deprivation of Liberty Safeguards activity rose by 600**%** after implementation in October 2011.

- The Respiratory Education project – patients now have an increased understanding of their condition and 77% leave their COPD review in primary care knowing what to do if their symptoms worsen. Recording of exacerbations has increased from 23% to 77% and practices can now offer support to those patients based on their exacerbation rates.

- Robotic surgery – developing expertise in this area has led to less invasive operations and this has enabled 70% of patients to go home the next day and improved the blood transfusion rate which is just 3% compared with 33% for traditional surgery.

- The Snakes & Ladders Project sparked an engagement from hospital based clinicians including doctors to tackle service improvement. Several projects were initiated as a result of this CPD including reviewing the processes for bed management and improving communication between tertiary and secondary care.

- Spotting the Sick Child showed a 7% decrease in referral activity in the Clinical Commissioning Group (CCG) compared with a neighbouring CCG in the first year and a 4% drop in year 2.

Can you identify examples of good or innovative practice in CPD?

The research indicated that examples of good and innovative CPD were plentiful. However it was difficult to identify the outcomes of good CPD and the extent to which it actually had an impact on practice. The number of examples where CPD was part of a completed learning cycle was limited. Similarly the extent to which reflection is encouraged in some Secondary Care Trusts was also very limited.

The 23 diverse case studies provide examples of CPD occurring across specialities and settings (primary care , secondary care and community care and across the UK). In order to confirm that learning has been effective, this study attempted to evaluate both the process and outcomes of the CPD experience. Outcomes, where evaluation of CPD by the learners occurred, include both subjective issues such as a modification of attitudes and more objectives measures like knowledge and skills acquisition that lead to a change in practice.[5]

The GMC has long advocated a shift from traditional forms of undergraduate and postgraduate teaching to an adult learning approach with a focus on the needs of the individual learner central to the process and involving problem centred learning.[6] Good and innovative CPD as illustrated by the diverse case studies incorporated established principles of effective medical education (adult learning theory) and adequate resources (administrative support, protected time for clinicians) in order to maximise the impact of the CPD on individual clinical practice and organisational goals, such as ensuring that core updates in knowledge and skills are provided regularly for clinicians and in order to drive improvements in patient services.

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[5] Morrison, J et al. (2003) Evaluation. *BMJ* 326:385-387
[6] GENERAL MEDICAL COUNCIL. Tomorrow's doctors. Recommendations on undergraduate medical education. London: GMC, 1993

According to Knowles,[7] adult learning theory is underpinned by five assumptions:

- adult learners are independent and self directing;
- adult learners have accumulated significant experience, which is a resource for learning;
- adult learners value learning that integrates with the demands of everyday working life;
- adult learners are more interested in immediate, problem centred approaches than in subject centred ones.
- Overall, adult learners are usually more motivated to learn by internal drives than by external ones.

By contrast however, experienced learners such as postgraduate trainees or hospital specialists may prefer a superficial and pedagogic approach to learning.[8]

The key elements associated with good or innovative CPD, which engaged learners, maximised participation in and access to the CPD activity, and additionally prompted organisations (Royal Colleges, NHS Trusts, Clinical Commissioning groups, Deaneries) to enable good and innovative CPD were as follows:

Evidence based and / or improving uptake of good practice guidelines (Case Studies 1.2,4, 5, 11,15,19, 22)

Fulfilling statutory training requirements (Case Studies 3, 6, 12,13,18,)

Multidisciplinary (Case Studies 3, 6, 12,13,18,)

Flexibility: timing of courses to maximise access; flexible CPD delivery to suit disciplinary group, 'hard to reach clinicians (1:1, group, uni- versus multidisciplinary CPD), choice of modules, core course material with additional learning modules (Case Studies 1-6, 10,11,13, 15,16, 17)

Link to CPD credits, appraisal and future revalidation requirements (Case Studies 3, 7, 8, 9, 10,15,17)

Encouraging reflective practice: learner identifies impact of CPD on practice, how new knowledge and skills may benefit patient care (Case Studies 5, 7, 10, 15, 16, 17)

Audit in order to monitor clinical outcomes of educational intervention with feedback to participants (Case Studies 2, 11, 23)

Peer benchmarking (Case Studies 8, 9, 11,22)

Web based resources which included pre-course and post course learning materials, self and course assessment, access to patient information (Case Studies 3, 6, 7, 8, 10, 14, 15, 22)

Quality assurance: structured trainer course with interval re-training, course evaluation and feedback embedded in process and enabling courses to become more responsive over time to learner and organisational need (Case Studies 1, 3, 7, 9, 12, 16 20)

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[7] Knowles, M et al. (2005) The Adult Learner. Sixth Edition. London, Elsevier
[8] Newble, D. (2002) Don't presume about experienced adult learners in medicine. BMJ 325:)

Local needs assessment: either by survey of learners or to enable organisational/ service delivery objectives to be better achieved by 'up-skilling' the workforce (Case Studies 1, 2, 7,10, 11, 12, 13, 14, 15, 16)

A 'local champion' to drive innovative CPD within an organisation (Case Studies 2, 20)

Interactive CPD within peer groups was overwhelming preferred

Didactic 'expert' teaching was preferred for unique technical skills eg Case Studies 20 'Robotic surgery '. However, didactic delivery of CPD was most effective where peer mentoring or 'real-life' problem solving vignettes/ activities were incorporated into courses (Case Study 3)

Dedicated, adequately resourced course administration was important (but often lacking) in order to provide effective evaluation and feedback , quality assurance of course content and sustainability of unique CPD which could include 'branding' and commercial marketing of courses).

Can you identify examples where CPD may have contributed to changes to an individual's practice and/or changes to the way care is provided either by a team or individual?

The process of identifying CPD which may have contributed to changes to an individual's practice and/or changes to the way care is delivered has been difficult. In very few cases were respondents able to speak about the outcomes of their CPD. There is a strong belief that CPD does have a positive effect on doctors' practice and performance as well as on the wider service delivery but in parallel to this belief there is an awareness that there is very little evidence for the impact of CPD. In most cases this is because there is little attempt to measure the outcomes of CPD. It may be that doctors define evidence at an unrealistically high level. The "gold standard" in medical research is the Randomised Controlled Trial (RCT) and many respondents talked about the difficulty of implementing an RCT in relation to CPD and stressed the difficulty of attributing change in practice or performance solely to CPD. Much educational research would adopt a lower level of evidence such as simple before and after studies without controls. Doctors in primary care were more likely to conduct simple audits to demonstrate improvements in clinical practice.

Where CPD is integrated with Personal Development Plans and the appraisal process, there needs to be documentation to show how individual doctors have demonstrated their learning and their implementation of that learning. Such integration seems to be confined to primary care. However we have found in this qualitative research that in many Acute Trusts the link between CPD and the appraisal process has yet to be established and the level of integration between CPD and the appraisal process in secondary care is extremely variable and usually more tenuous. The level of integration in Acute Care does not seem to correlate with the size or type of Trust. There were several very large Acute teaching hospitals where the CPD process had no links at all with the appraisal system.

Examples of the contribution made by CPD are shown in the case studies included in the table illustrating benefits in Theme 2.

Can you identify examples of barriers encountered by individuals or organisations when implementing aspects of or learning from CPD and how these barriers were overcome?

The main barriers encountered by individuals or organisations when implementing aspects of learning from CPD were as follows:

- Time
- The lack of integration between CPD and the appraisal process
- Idiosyncratic approach to CPD
- The lack of strategic organisational input in identifying CPD and supporting its implementation
- Lack of organisational support especially in reflection
- Tick box mentality.

Over and above finding the time to attend CPD, doctors also struggle to free themselves from clinical pressures to spend the time they require to reflect on their learning and to consider how to implement their learning particularly where this may be part of a bigger service change.

The lack of integration between CPD and the appraisal process in some Trusts means that doctors in these Trusts are not challenged to demonstrate the implementation of their learning. All too often CPD exists in isolation at the whim of individual doctors and is not part of a learning cycle. Implementation of learning can happen in these circumstances but seems to be more haphazard.

Other than mandatory training it seems to be relatively common for organisations to take little interest in the training needs of the doctors that they employ as if they work in a vacuum. Exactly what CPD is undertaken is usually decided by individual doctors sometimes in collaboration with their supervisors but the employing organisation is often not perceived to have a major interest in this.

Where organisations are interested in compliance, as in mandatory training for child protection or Do Not Resuscitate training or the Mental Capacity Act, then the Trust may go to some effort to deliver the CPD and support its implementation in a number of ways in addition to the training itself.

There was a substantial variation in the extent to which Trusts recognised the role of reflection and supported the process. Some respondents (predominantly based in Acute Trusts) did not recognise the importance of reflection in implementing CPD, did not encourage doctors to undertake reflection and did not support the process.

4.1. Limitations of the study

Qualitative methodology provides an opportunity to analyse rich data from a small number of participants where transferability of findings rather than 'generalisability ', as in quantitative

methodology, is sought. As such , the reader needs to make interpretive judgements based on the context of his/ her own practice and working environment.

NHS changes , particularly with regard to the devolution of primary care trust responsibilities to relatively new clinical commissioning groups (CCGs) meant that the interviews were undertaken here in the context of rapid change in terms of PCT responsibilities, particularly in relation to CPD and personnel leaving as well as a changing role in existing and nascent primary care organisations.

Despite rigorous attempts to identify case studies from as diverse a range of settings and specialities as possible; a lack of illustrative case studies was apparent in some specialities whereby CPD was not required to specifically demonstrate impact / and/ or there was no central way of identifying such activities via the designated CPD lead for that organisation or speciality. Primary care contacts were more easily able to identify case studies and this may have biased the sampling framework.

Attempts were made to include the private sector in this report but despite numerous approaches we unable to do so. As the private providers were unable or unwilling to comment in detail on this issue, in a short preliminary interview it emerged that where doctors work for both the NHS and the private sector, the private hospitals rely heavily on the NHS employer of their staff to take responsibility for their CPD

5. Key Findings and Recommendations

1.Use of GMC Guidance

Little evidence was found that individual doctors and Trusts were familiar with the previous GMC Guidance on CPD [2004] and were using its principles or framework to implement their CPD programmes.

The GMC has started to address this issue already with the launch of latest guidance on CPD (http://www.gmc-uk.org/education/continuing_professional_development/cpd_guidance.asp).

Professor Sir Peter Rubin, Chair of the GMC, said: 'Continuous advances in medical science mean that all doctors need to ensure they are always at the leading edge of medical practice. 'Lifelong learning is the key to ensuring that doctors keep up to date and this new guidance will support doctors in their efforts to achieve this and in their preparation for revalidation. We hope they will use it to reflect on how their learning and development improves the quality of care they provide for patients and for the service in which they work.'

The GMC should consider appraisal of the impact of the guidance, particularly from the perspective of employer organisations, in addition to individuals, with regard to current appraisal procedures and with the forthcoming introduction of Revalidation to England in 2012. Again the GMC is now starting work to embed the guidance in local process. **[Recommendation 1]**

2. Culture and Environment:

Doctors should continue to assume responsibility for taking part in and recording their own CPD. However there was little evidence found by this study that CPD was helping them to improve their professional effectiveness. Relatively few examples were found of the direct impact of CPD on patient care and little attempt is being made currently to evaluate the effectiveness of CPD because of the perceived complexity of doing so in a robust way and because of the potential resource implications.

Of particular note, no evidence was found of any patient/public involvement in Doctors' CPD. Both of these issues also need to be addressed by Trusts and the GMC. **[Recommendation 2]**

Although there was some evidence that the value of informal learning was recognised, such learning cannot easily be measured or assessed. However it is important that Trusts and the GMC continue to recognise and support informal learning as an important component of CPD. **[Recommendation 3]**

There is no doubt that General Practice [GP] is well ahead of all the other specialities in its systems for supporting CPD and the cycle of implementation of learning into Practice. There was some good evidence from GP that the way CPD is undertaken depends not only on specialty but also on current priorities and opportunities as well as individual learning styles and preferences.

Completion of the learning/implementation cycle should become a CPD 'norm' i.e. All doctors should produce evidence at their appraisals/revalidation that they have implemented their learning in clinical Practice [where appropriate] using methods such as the audit of clinical care as well as patient and

colleague feedback etc. There is a need for continuing support from Trusts for doctors to implement their CPD learning into Practice.

Trusts, in particular need to support good educational models of CPD and the GMC needs to encourage the dissemination of such models by the Royal Colleges and between the specialities - in particular those which emphasize the importance of applying individual learning to Practice. **[Recommendation 4]**

3. Content/Process of CPD Activity

There was some good evidence that the CPD which was being undertaken was relevant to Practice although little evidence [if not outright hostility in some Trusts] of inter-professional or team learning. Although a very wide variety of CPD was delivered and recognised as potentially valuable in improving patient care, the considerable benefits of learning across professional disciplines and boundaries need to be encouraged and supported by Trusts. **[Recommendation 5]**

In addition, although the importance of statutory learning, such as the current mandatory training in child safeguarding, was well recognised and delivered by the Trusts, unfortunately this was sometimes the sole driver of CPD in some of the Trusts including PCTs. CPD should be more than statutory learning!

No evidence of CPD linked to the responsibility of Doctors to look after their own health and wellbeing to ensure patient safety was found in our study. It is, however, widely recognised that there is significant work-related morbidity amongst doctors (eg 2008 Department of Health report on "Mental health and ill health in doctors" http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_08 3066. What was remarkable in our interviews was that none of our respondents mentioned the importance of self-care and self-management by doctors themselves as a component of their CPD. It should be noted that we did not specifically ask about this issue. The issue of the physical and mental wellbeing of doctors, particularly with the increasing number of complaints, is, in our view, an important issue which needs to be emphasized in the new GMC Guidance as well as highlighted to all Trusts. **[Recommendation 6]**

Most encouragingly – the importance and contribution of reflection to CPD was recognised by almost all interviewees although to what extent this was formalised and structured varied enormously. How much was only 'lip service' is unknown although the Case studies do provide some evidence of effective reflection being undertaken. The GMC should continue to emphasize the central role of reflection in CPD and the importance of a systematic approach to this. **[Recommendation 7]**

There was good evidence that CPD [as per the current GMC Guidance] is starting to be linked to Appraisal and certainly a great of hope is being invested by Directors of Education that revalidation will give a big push to the quality of CPD and the importance of applying learning to Practice by the completion of cycles of implementation.

4. Role of Organisations

Trusts were generally helpful in providing support/advice on what CPD needed to be undertaken although they currently have little role in the quality assurance or quality enhancement of CPD. Trusts need to continue to develop their role in CPD programmes by not only providing general and local guidance but also in assessing and recognising courses. **[Recommendation 8]**

Most organisations were flexible enough to recognise that a whole variety of learning methods including non traditional methods of CPD [e.g. distance learning] were valid within the context of CPD and this is illustrated by many of the case studies.

It was disappointing that many of the Trusts appeared not to be familiar either with the previous GMC Guidance on CPD [2004] nor with the 'ten principles of CPD' document published by the Academy of Medical Royal Colleges which is designed to support the CPD programmes of the individual Colleges and Faculties. The use of both the principles highlighted in the new GMC Guidance for CPD [2012] and the framework outlined in the Academy document is highly recommended when new CPD programmes for Doctors are being developed. **[Recommendation 9]**

Each Medical Royal College has, of course, a responsibility to support the CPD of its members and should at the very least ensure that members are familiar with and using the CPD principles of their own College, the GMC Guidance and/or the AoMRC framework when planning their individual CPD.

If Organisations are to support and facilitate the CPD of Doctors, then resources need to be allocated to ensure that high quality CPD takes place within a framework and infrastructure provided by the Organisation and that all Doctors have sufficient protected time to undertake effective CPD. **[Recommendation 10]**

5.Providing CPD opportunities for Doctors

There are particular issues around a lack of provision of CPD for doctors not in conventional positions [e.g. locums, portfolio careers, outside the training grades etc] or employed by private organisations from whom a very poor response was received.

The GMC should use its position to highlight the importance of employers making CPD provision available to such doctors so that they can not only meet the requirements for revalidation but also for the benefit of patients. **[Recommendation 11]**

All employing organisations must continue to recognise and meet their responsibilities to provide CPD opportunities for ALL doctors whom they employ. **[Recommendation 12]**

Appendix

Appendix 1

Acute Topic Guide telephone interviews – Impact of CPD vs 6

Name of organisation	
Type of organisation	
Telephone no.	
Date of interview	
Respondent name	
Respondent position	
Respondent contact details	

We are conducting a project on behalf of the General Medical Council to understand the impact of continuing professional development on **doctor's** performance, colleagues and wider team, patients or service improvement. We are ringing today to find out there is anyone in your organisation who might be able to talk to us about CPD - continuing professional development sometimes also known as continuing medical education (after completion of speciality training) .

1. General CPD background – Could you describe briefly how CPD is organised within your Trust?

2. To what extent is CPD linked to the appraisal system?

3. Are doctors expected to demonstrate the impact as a result of CPD? And if so how do they do that?

Prompt: Are outcome measures identified in PDPs (Professional Development Plans) Prompt: use of local audits?

4. To what extent is CPD delivered centrally across a Trust? Prompt: Which elements?

5. To what extent is CPD planned to meet the needs of the Trust?

6. To what extent do you believe that doctors' involvement in CPD has a real impact on their practice and performance?

7. Whist it may be difficult to attribute cause and affect, do you think that CPD can lead to improvements in patient or service outcomes?

8. Is it ever possible to see benefits from CPD for colleagues and the wider clinical team, employers or the organisation as a whole?

9. To what extent do you believe that those participating in CPD are supported in the process of reflection of learning and development? Prompt: Why do you say that?

10. In your opinion what are the main barriers to implementing learning from CPD?

Prompt:

What stops successful implementation?

What could be done to overcome these particular hurdles?

The GMC are specifically interested in examples of good practice in CPD or innovative practice in CPD. We are seeking to collect case studies of good practice which might be able to demonstrate impact.

(NOTE TO INTERVIEWER – WE ARE ONLY INTERESTED IN CPD ACTIVITIES FOR DOCTOR'S ALTHOUGH IT COULD INCLUDE MULTI-DISCIPLINARY CPD ACTIVITIES. NB. IN ACUTE TRUSTS, PROBE FOR A VARIETY OF SPECIALITIES)

Are you aware of any particularly good examples of CPD activities for doctors within your organisation which might have had some impact? We are looking for examples where CPD may have contributed to change either in an individual's practice or the way care is delivered. *IF YES – take down as many details as possible, in particular ascertain contact details for the specific CPD project.*

Example 1

CPD project name	
Organisation if different from above	
Clinical speciality	
Brief description	

Likely or perceived impact	Prompt: Impact on doctor performance/ practice: Probe: Impact on doctors' competence and confidence Impact on colleagues and wider team Impact on patients: Impact on service improvement:

What barriers were faced in applying the skills and knowledge delivered by the CPD. Are you aware of how this particular CPD activity successfully overcame these barriers?	
Date implemented – How long ago?	
Numbers if known	
Duration	
If we wanted to look at this example in more detail who do you advise we speak to? Contact details for lead person	

Prompt for further examples of good practice in CPD: Are you aware of any other examples where CPD may have contributed to an individual's practice or the way care is delivered?

If there are any more examples, work through above questions again and record below:

Appendix 2
Primary Care Topic Guide telephone interviews – Impact of CPD vs 6

Name of organisation	
Type of organisation	
Telephone no.	
Date of interview	
Respondent name	
Respondent position	
Respondent contact details	

We are conducting a project on behalf of the General Medical Council to understand the impact of continuing professional development on **doctor's** performance, colleagues and wider team, patients or service improvement. We are ringing today to find out there is anyone in your organisation who might be able to talk to us about CPD - continuing professional development sometimes also known as continuing medical education (after completion of speciality training) .

1. General CPD background – Could you describe briefly how CPD is organised within your PCT?

2. To what extent is CPD linked to the appraisal system?

3. Are GPs expected to demonstrate the impact as a result of CPD? And if so how do they do that?

Prompt: Are outcome measures identified in PDPs (Professional Development Plans) Prompt: use of local audits?

4. **To what extent is CPD delivered centrally across a PCT?**

5. **To what extent is CPD planned to meet the needs of the PCT or a general practice?**

6. **To what extent do you believe that doctors' involvement in CPD has a real impact on their practice and performance?**

7. **Whist it may be difficult to attribute cause and affect,   do you think that CPD can lead to improvements in patient or service outcomes?**

8. **Is it ever possible to see benefits from CPD for colleagues and the wider clinical team, employers or the organisation as a whole?**

9. **To what extent do you believe that those participating in CPD are supported in the process of reflection of learning and development? Prompt: Why do you say that?**

10. **In your opinion what are the main barriers to implementing learning from CPD?**

Prompt:

What stops successful implementation?

What could be done to overcome these particular hurdles?

The GMC are specifically interested in examples of good practice in CPD or innovative practice in CPD. We are seeking to collect case studies of good practice which might be able to demonstrate impact.

(NOTE TO INTERVIEWER – WE ARE ONLY INTERESTED IN CPD ACTIVITIES FOR DOCTOR'S ALTHOUGH IT COULD INCLUDE MULTI-DISCIPLINARY CPD ACTIVITIES. NB. IN ACUTE TRUSTS, PROBE FOR A VARIETY OF SPECIALITIES)

Are you aware of any particularly good examples of CPD activities for doctors within your organisation which might have had some impact? We are looking for examples where CPD may have contributed to change either in an individual's practice or the way care is delivered. *IF YES – take down as many details as possible, in particular ascertain contact details for the specific CPD project.*

Example 1

CPD project name	
Organisation if different from above	
Clinical speciality	
Brief description	

Likely or perceived impact	Prompt:
	Impact on doctor performance/ practice:
	Probe: Impact on doctors' competence and confidence
	Impact on colleagues and wider team
	Impact on patients:
	Impact on service improvement:

What barriers were faced in applying the skills and knowledge delivered by the CPD. Are you aware of how this particular CPD activity successfully overcame these barriers?	
Date implemented – How long ago?	
Numbers if known	
Duration	
If we wanted to look at this example in more detail who do you advise we speak to? Contact details for lead person	

Prompt for further examples of good practice in CPD: Are you aware of any other examples where CPD may have contributed to an individual's practice or the way care is delivered?

If there are any more examples, work through above questions again and record below:

Appendix 3

Case study Topic Guide	
CPD project name	
Organisation if different from above	
Clinical speciality	
Multi-disciplinary - specify	
Brief description Probe: How did this activity come about?	

Likely or perceived impact What do you see as the main outcomes of this activity?	Prompt: Impact on doctor performance/ practice: Probe: Impact on doctors' competence and confidence Impact on colleagues and wider team

	Impact on patients: Impact on service improvement: Are there any particular outcome measures which might have changed as a result of this activity? E.g. Numbers treated, fewer admissions et
Who else could we talk to about this case study who might be able to give us more detail or a different perspective? Probe as appropriate: Other colleagues? Managers? Trainers? Patients/ Patient groups	
It is often difficult to implement learning. What have you learnt from delivering this CPD activity?	

What in particular helped participants deliver their learning in practice?	
What barriers were faced in applying the skills and knowledge delivered by the CPD. How did you overcome these barriers?	
To what extent were doctors able to reflect on their learning in order to implement this? Was reflection an important element of the overall implementation?	
Have you written it up at all? Could we see a copy?	

Date implemented – How long ago?	
Numbers if known - ie how many doctors have benefited from this?	
Duration	
Is this CPD still continuing? Are there any plans to develop it further or roll out wider? What might you do differently in the future?	
If we wanted to look at this example in more detail who do you advise we speak to? Contact details for lead person	
Are you happy for this to	

be written up as a case study? Assuming yes, we can send you a copy for your to review and annotate if you wish.	
Do you wish to identified in the case study or would you prefer it to be anonymised?	