The Royal College of Surgeons of England

Continuing Professional Development
A new direction for the College

EXECUTIVE SUMMARY

In anticipation of the Chief Medical Officer's report, *Good doctors, safer patients*, a working party was established under Mr Chris Chilton to review College policy on Continuing Professional Development (CPD). This paper has been produced to set out the findings of the working party in order to enable College Council to decide on the future direction of College CPD policy.

CPD is part of the local NHS appraisal process and a requirement to complete CPD activity is set out in the GMC's *Good Medical Practice* and *Good Surgical Practice*. Since changes to the Senate of Surgery policy in 2004, the College no longer requires individuals to collect CME points or other evidence of CPD, though surgeons are still expected to take part in, and keep a record of, CPD activity.

A number of factors have influenced the need for a review of College CPD policy, including the development of e-learning technology and concerns about patient safety in light of the Shipman Inquiry. Most significantly, the Chief Medical Officer's review of medical professional regulation, *Good doctors, safer patients*, sets out proposals for a dual system of regulation that includes specialist recertification set by the College and specialist associations.

Evidence of CPD and reflection on learning is likely to form part of the criteria for assessment in any recertification system developed in light of the report.

A compulsory requirement for recording CME points as evidence of CPD is common in other systems of medical regulation. The majority of UK medical Royal Colleges have compulsory, credits-based systems. In Australasia, recertification as a fellow is dependent on achievement of a certificate of CPD and the American medical system requires all doctors to achieve a required number of CME points.

In light of the proposals in *Good doctors, safer patients*, it is recommended that the College should establish a compulsory and quantifiable measure of CPD that will form part of the requirements for recertification, and review whether this can be achieved without reintroducing a points-based system.

However, the main purpose of the College's CPD policy should be to support surgeons' professional development and to facilitate improvement in patient outcomes. The link between CPD and appraisal should be explicit in any CPD guidelines developed, with emphasis on the need for CPD to reflect practice need. Reflection on learning should also be a requirement of College policy and a facility for recording reflection should be built into any e-portfolio system developed by the College to support recording evidence of CPD.

It is essential that the College and Specialist Associations should reach agreement about their respective roles at an early stage. The proposals in this document envisage the College playing an 'umbrella' role, providing a framework for the associations to deliver specialty specific CPD requirement. This could include recording CPD activity, accrediting courses and developing and providing generic courses. The College should also support individual development, research and participation in CPD and enable fellows and members to gather evidence of CPD.

SECTION 1 – INTRODUCTION

Since the closure of the Intercollegiate CPD office in 2003, The Royal College of Surgeons of England no longer keeps central records of individual CPD activity or accredits courses for CPD purposes.

The CPD working party was established in March 2006 to review the College's CPD policy in anticipation of the Chief Medical Officer's report and in light of other developments, such as the growth of e-learning techniques. The membership of the working party is detailed in Appendix 1. In order to base their recommendations on the best available evidence and good practice from other areas of medicine and beyond, the working party met with a range of professionals with expertise relating to CPD (detailed in Appendix 2).

The College has a commitment to provide strong leadership and support for surgeons in all matters relating to their surgical practice, throughout their careers. This includes supporting surgeons through their appraisal process, by setting a clear set of standards, provision of the educational courses and facilitating the recording of CPD.

This paper has been produced in order to enable College Council to decide on the future direction of College policy on CPD for surgeons, and identify further areas of work necessary for the College to support fellows and members in their CPD.

2. POLICY BACKGROUND

2.1 GMC position

The duties of a doctor registered with the GMC includes a duty to maintain a good standard of practice and care. Guidance on CPD is set out in the GMC's 2004 document *Continuing Professional Development*[1] and reflected in *Good Medical Practice*[2]. The latest version of *Good Medical Practice*, published in October 2006, states that "*you must keep your knowledge and skills up to date throughout your working life. You should regularly take part in educational activities that maintain and further develop your competence and performance*." It also places a duty on doctors to *"maintain a folder of information and evidence, drawn from your medical practice".*

2.2 The College and Senate Position

Prior to 2004, the College ran a CPD system based on an individual meeting the requisite number of CME points, which were awarded based on the number of hours spent undertaking CPD activities. However, in 2004 the system was abandoned in light of revised Senate guidance on CPD *Managing your performance: dossier of guidance on Continuing Professional Development for Surgeons*[3].

The revised guidance no longer incorporates the collection of numerical points or credits from performing activities contributing to CPD, consequently the College no longer requires individuals to collect CPD points. However, the fundamental principles of Senate guidance remained unchanged. The guidance is designed to assist surgeons in planning and recording their CPD. It is based on the principle of self-accounting with quality assurance through the appraisal process. The reason for the move away from a points based system was a change of emphasis from quantitative measures of CPD to an emphasis on quality and appropriateness of CPD to the individual surgeon's professional development.

2.3 Specialist Associations

The nine surgical Specialist Associations are responsible for setting CPD criteria within their area of specialist practice. Although the Senate of Surgery CPD guidance no longer requires surgeons to record CPD points, a minority of specialist associations still operate a point-based CPD system. The College's CPD policy as currently stated does not reflect this variation across specialties.

2.4 The Academy Position

The Academy of Medical Royal Colleges have set out ten principles for CPD in their 2005 paper[4]. The paper highlights the variation in CPD schemes across the areas of medicine and sets out ten simple principles that form the foundation of a good CPD system, including the need for CPD to reflect professional practice and performance, the need to audit a relevant sample of participants and the use of a reflective statement as evidence of participation in CPD. The ten principles are included in Appendix 3.

The Directors of Continuing Professional Development Committee within the Academy of Medical Royal Colleges has begun an important programme of work around CPD and the link between CPD and revalidation. Any College policy will need to reflect and build on the findings of the Academy. Current areas of work include an assessment of the role the Academy could play in supporting appraisal, research relating to measuring the impact of CPD by outcome assessments and modelling possible structures for post-CCT credentialing.

3. DRIVERS FOR CHANGE

3.1 Patient Safety

The recommendations of *The Shipman Inquiry: fifth report*[5] identified a number of weaknesses in the regulatory systems for doctors, including concerns about the structure and function of the General Medical Council (GMC). The report highlighted the need for a stronger regulatory system to protect patients. Sir Liam Donaldson was asked to review the regulation of doctors in light of the recommendations of the report.

There is a public need for clear, consistent standards as reassurance for patients, the public and employers that doctors are deserving of trust. A clear structure of CPD is part of the professionalism by which doctors can provide this reassurance.

Following publication of acknowledging *Safety First*[6] patient safety is now a central priority for the Department of Health. Recommendation 11 of the report calls for the NHS Institute for Innovation and Improvement to work with the medical Royal

Colleges to ensure that advances are made in education and training to support patient safety, including continuing education.

3.2 *Good doctors, safer patients*

In July 2006, the Chief Medical Officer for England, Sir Liam Donaldson, published his review of the regulation of medical professionals *Good doctors, safer patients*[7]*.* The report concludes with 44 recommendations.

The recommendations include proposals for a system of revalidation for all doctors, based on a dual process of re-licensing (renewal of a doctor's licence to practice) and specialist recertification (see Appendix 4). Doctors would be expected to meet standards for generic medical practice and standards for specialist practice, set by the relevant Royal College.

These proposals, if accepted, would give the medical Royal Colleges a key role in the recertification process. The relevant College and specialist associations, would be responsible for setting a clear and unambiguous set of standards for their area of medical practice. Specialist recertification would then be dependent upon "membership of, or association with, the relevant medical Royal College[8]" and renewal would be based upon a comprehensive assessment against the standards set by that College. Recertification would be renewed at regular intervals of no longer than every five years.

Though the role of Continuing Professional Development isn't detailed in the recommendations, the implication is that any system of revalidation would be dependant on a rigorous system of appraisal and that this would have to be directly linked to CPD. Recommendation 31 of the report states that evidence for recertification "may be drawn from clinical audit, simulator tests, knowledge tests, continuing professional development or observation of practice."

3.3 Development of E-learning technology

The general trend away from taught courses to new learning methods such as work based learning and e-learning, sets a number of challenges for the College. This includes the need to review the portfolio of support provided to support consultant surgeons' development, the courses it provides and to investigate opportunities for e-learning, CD-Rom and other distance learning packages.

There are a number of issues arising from this trend, including the need to assure the quality of a range of learning programmes delivered through a variety of media. There is also a danger that a minority of surgeons may rely over-heavily on e-based learning with a resulting reduction in learning with and from peers. A revised CPD policy may be necessary in order to steer surgeons more clearly towards a balanced package of learning.

Dr Bernard Maillet, Secretary General (UEMS EACCME): "*For any CPD system to be effective there needs to be a mix of evidence of learning: peer review meetings attended, long distance learning and credits gained."*

4. WHAT IS CPD?

4.1 Definition

The CPD Working Party agreed to use the definition of CPD in the GMC document *Continuing Professional Development*[9].

"Continuing Professional Development (CPD) is a continuing learning process that complements formal undergraduate and postgraduate education and training. CPD requires doctors to maintain and improve their standards across all areas of their practice… CPD should also encourage and support specific changes in practice and career development. It has a role to play in helping doctors to keep up to date when they are not practising."

Good CPD should meet the professional development needs of the individual surgeons, whilst meeting the needs of the health service and resulting in better patient care.

4.2 Local Processes for CPD

CPD is part of the appraisal process and is recorded in the individual's Personal Development Plan (PDP). The CPD cycle consists of an initial learning needs assessment, undertaking activity to meet the needs identified and evaluating the effectiveness of the learning activity.

The individual's PDP records their wants/needs in relation to learning; how they plan to meet this need, the resources or support required, the success criteria and timeframe for completion.

4.3 Elements of Individual CPD

Appraisal

As outlined above, the appraisal process reviews a doctor's performance, sets out personal and professional development needs in light of performance and practice, agrees a personal development plan for these needs to be met and reviews the effect of the learning. Appraisal creates a link between service objectives and the objectives of the individual and their department. Appraisal should also offer an opportunity for doctors to discuss and seek support for their participation in learning activities.

Development

CPD needs will change over the course of a surgeon's career as they advance from foundation years to new areas of responsibility such as clinical directorships and management. Likewise the support required from the College should change to meet these changing CPD requirements, through the development of appropriate courses, the provision of information and guidance and providing a source motivation and leadership to surgeons throughout their career.

Learning methods

Surgeons learn through a variety of methods throughout their career, including formal learning through attendance at courses and informal learning through practice-based experience. Not all of these forms of learning are possible to measure and formal 'credit based' systems of CPD are in danger of ignoring important aspects of professional learning. Experiential learning is central to the development and retention of 'intuitive' skills central to a complex craft such as surgery.

Reflection

Professional development demands reflection on everyday practice as well as educational episodes in order to change strategy and apply it to clinical practice. Reflection is central to effective CPD. The current version of *Good Medical Practice*[10] includes a duty to *"reflect regularly on your standards of medical practice."*

4.4 Elements of CPD systems

Recording

All CPD systems considered by the Working Party facilitate the recording of CPD activity through a standardised format. Some systems still contain both a computer-based and paper-based format for recording CPD. However, the vast majority of medical professionals now have computer access and paper based formats are generally being phased out. Most modern CPD systems are available online.

The College currently recommends surgeons to use the Senate of Surgery Proforma for recording their CPD activity but provides no on-line CPD recording facility.

Credit points

Most CPD systems considered operate on a system of points or credits based on attendance at courses, where individuals must meet a minimum requirement. Simple schemes may be based on recording the number of hours spent undertaking CPD. A points based system awards an agreed number of points for time spent undertaking CPD. Points based systems can be used to direct individuals to particular methods of learning, by awarding points at a higher rate for favoured learning methods.

Prior to 2004, the College CPD system was based on meeting a requisite number of Continuing Medical Education (CME) points, awarded on the basis of the number of hours spent on the activity. The system was abandoned due to a number of weaknesses with the process:

- The system was non compulsory – no action was taken against those not completing CPD.
- No evidence to verify attendance was acquired.
- There was no quality assurance of the courses attended.
- Attendance at courses per se is a poor measure of professional development.

Course accreditation

Accrediting courses is a means of ensuring that the courses undertaken have met the required standards and are appropriate to the surgical specialty, if not necessarily matching the individual's learning plan.

There are various methods of accreditation, ranging from complicated systems of grading courses, to a kite mark that the course meets a requisite standard. Accreditation may be given to individual courses or to learning providers.

The increasing use of internet materials and CD Roms as part of CPD raises a particular issue with regard to quality assurance.

4.5 International CPD Schemes

Europe

Accreditation of events occurs in most of the 28 European countries. CPD is mandatory in half of these and recommended in the rest. The Belgium system uses a reward based system – doctors are paid extra upon completion of CPD.

Statements 1 and 2 of the Standing Committee of European Doctors 2002 state that there is an ethical duty and fundamental right for doctors to engage in CPD and that every physician should have an individual CPD/CME plan.

USA

America accredits courses for CME points against criteria of:

- Purpose and mission
- Educational planning and evaluation
- Administration

Australasia

Under the Australasian system, recertification as a fellow is dependent on achievement of a triennial certificate of CPD. The College operates a compulsory points-based system, with CPD activity divided into categories, such as clinical governance and maintenance of knowledge and skills. Each individual must achieve a minimum number of points in each category. The system is described in more detail in Appendix 5.

The requirements for all surgeons over the 3-year period are to:

- Undertake an annual peer review surgical audit.
- Be credentialed at an approved hospital.
- Accrue 30 points for clinical governance and evaluation of care.
- Accrue 210 points for maintenance of knowledge and skills, including attending at least one approved scientific meeting.

4.6 Domestic CPD Schemes

The majority of medical Royal Colleges have a compulsory, credits based, CPD requirement. In most of these the minimum requirement is 50 hours per year.

Some Colleges break CPD into categories and have minimum CPD requirements within each category and many of these include a minimum requirement for external courses. For example the Royal College of Psychiatrists has a minimum annual requirement of 50 hours per year, 20 of which must be external courses.

5. FINDINGS

The CPD working party heard evidence from a range of experts. All of the professionals that the working party spoke to agreed that the College would need to play a more active role in CPD, particularly in light of the CMO's report. The main findings of the evidence sessions are as follows:

5.1 Links with revalidation

CPD would play a key role in the type of revalidation system described in *Good doctors, safer patients*. CPD would provide a record of continuing education and support the appraisal process by identifying future learning needs arising from practice. Evidence of CPD and reflection on learning is likely to form part of the criteria for assessment of any recertification system developed.

The recertification system that is eventually agreed and implemented following *Good doctors, safer patients* will dictate the overall framework under which CPD operates, though it is highly likely that evidence of CPD will form a part of that system.

> Professor Janet Grant, Professor of Education in Medicine, Open University: *"CPD has got to be properly managed because the government has set it into the context of clinical governance and revalidation so that means you've got to find a way of managing it and you haven't got a choice."*

5.2 Elements of CPD

The goal of CPD should be on improving professional performance and patient outcomes and not the activity itself.

Reflection

Attendance at a course, or a conference, is no guarantee that learning has taken place. A reflective statement can therefore be a better indicator of learning than an attendance certificate. This is supported by research on surgical education in Australia, which showed that surgeons commit a considerable amount of time to CME but much of this is spent in passive educational activities.[11]

The College currently encourages reflection on courses attended. The Senate of Surgery proforma (see appendix 6) for recording CPD activity, which is currently recommended by the College, includes a section for recording '*the contribution of activity to practice'.* The Senate Guidance on CPD recognises reflective practice and reflective learning as core concepts that underpin medical education. "*Surgeons should constantly review their practice, discussing it with surgical colleagues and members of the multi-professional team…Surgeons learn 'reflectively' by asking questions as to what has been learnt and how this can be applied to professional practice*"[12]."

Other CPD schemes incorporate reflection as a key element. For example:

- The Federation of Physicians' system only awards credits once reflection on the event attended is added to the online record.
- The British Psychological Society's CPD scheme requires practitioners to review and reflect on their learning the knowledge and skills acquired (outcome) and how it applies to practice.

Reflection does not necessarily mean that it will be possible for every surgeon to change clinical practice in light of learning. This could be due to a range of factors including the structure of the clinical team, lack of resources and managerial resistance. However, reflection and reinforcing learning is still possible.

Professor Janet Grant "*You can't always implement what you've learnt but you can reinforce it in other ways. Talking about it to colleagues/managers motivation is the key."*

Recommendation
Reflection is an essential element of CPD and any online system developed to support CPD should include a compulsory section for reflection.

Standards
As discussed above, participation in learning activity and reflection upon that activity is an essential part of professional practice and any standards set by the College for the purpose of professional recertification should include standards relating to CPD. A compulsory and quantifiable measure of CPD is likely to form part of the requirements for recertification, in order to demonstrate that time and effort have been dedicated to professional development. This issue is discussed further under Credits and Point Counting below. In the long term the College should endeavour to reach a stage where CPD can be demonstrated through outcomes achieved rather than by recording evidence of learning activity.

Support
The College has an important role to play in selling the benefits of CPD to its Fellows, Members and Affiliates at all stages of their surgical career. This could include producing information and best practice documents to support appraisal and working with the specialist associations to signpost surgeons to courses, information and advice.

Janet Grant *"Doctors are lifelong learners and do work in a rich learning environment. The profession has to show the benefit of CPD."*

A move to a mandatory system of recording CPD would need to be backed up by strong support from the College. In particular, any move to a computer-based system for recording CPD would need to include provision of information and support to Fellows and Members, with an appropriate time-frame for implementation that would enable all Fellows and Members to become familiar with the system, the use of reflective statements and any portfolio used to record the information.

Timeframes
The working party heard evidence from the British Psychological Society (BPS) about the timeframes involved in establishing a CPD system for its members. Victoria Burt was recruited by the BPS in 2001 with a remit to establish a mandatory system of CPD. Her work began with a consultation with members, a pilot study based on the draft guidelines and the development and testing of an online system for recording CPD. The online system was operational from 2004 and compulsory from 2006, though sanctions for non-compliance will not be implemented until 2007. In summary, it will have taken six years from the initial consultation and pilot to a fully operational system with sanctions.

Miss Burt's evidence suggests that the College should allow several years from its initial consultation with members to the introduction of a fully operational CPD system. This in turn implies that developmental work should begin as a priority.

Victoria Burt, CPD Manager, the British Psychological Society: "*We have spent a*

long time with people on the phone trying to persuade them round and explaining it. I think having some sort of assistance there is a good thing. I think we would have lost a lot of good will if we hadn't had that available."

5.3 CPD Systems

Credit points

There are several weaknesses to CPD systems based on points or credits for attendance at courses. Most importantly attendance at courses in itself is a poor measure of professional development and gives no indication of the relevance of learning to an individual's needs or of how effective learning has been in changing practice or improving patient outcomes. In short, there is little benefit to a system where the collection of CPD points is the sole requirement of CPD policy.

Dr Malcolm Lewis, GMC: *"Points just show you've attended something. You could have been asleep at the back of the room."*

However, in spite of these weaknesses, most CPD schemes rely on some form of points or credits to demonstrate evidence of CPD where there is a compulsory element to the scheme. There is a strong argument that any CPD system rigorous enough to facilitate a process of revalidation would need some form of compulsory points system.

Bernard Maillet: *You have to use credits because you have to measure something.*

A points-based system could be effective if it is linked with appraisal to ensure the relevance of the learning and to enable reflection on the courses attended. However, such a system should be as flexible as possible in order to enable the individual to choose learning activity that reflects their specialty and sub-specialty, current issues in practice, the stage in their surgical career and their personal choices and interests.

Dr Malcolm Lewis: *"You could say that over a five year period that you expect that you would get say 50 points from College accredited courses… and that you would reflect upon that course attendance in your annual appraisal. Then you're getting more than just attendance you're getting people to think about what they were doing there what they got from it*."

The Australasian model (see Appendix 5) combines strict criteria with a choice of learning methods to meet these requirements, including peer review, meetings attended and distance learning. Such a system would enable specialty associations to set compulsory courses in their specialty, yet still give the individual the freedom to choose their own method of learning.

Professor Janet Grant: *"Doctors learn effectively in different ways, there is no best way of learning."*

Recommendation

The College should establish a compulsory and quantifiable measure of CPD that will form part of the requirements for recertification, and review whether this can be achieved without reintroducing a points-based system.

5.4 Course Accreditation

Accreditation acts as a guide for individuals seeking appropriate courses and provides evidence of quality to the Trust or other employing organisation, which can help secure funding and time off to attend. The Education Department already double badges some courses.

Dr Mike Watson, Chair of Academy of Medical Royal Colleges Directors of CPD Committee: "*Approval of activities does play a role in steering people towards suitable courses, so a role for the College in kite marking activities could be appropriate*."

However, accreditation is a time-consuming process and involves a considerable cost in terms of time spent validating even a small percentage of courses, which is likely to fall on the specialty associations.

Recommendation
The College should review the accreditation of courses in light of work of the recertification process developed in light of *Good doctors, safer patients*.

5.5 Links with professionalism

In his evidence to the working party Harry Cayton, National Director for Patients and Public at the Department of Health, defined a good doctor based on the following five relationships:

- Relationship with skills / knowledge
- Relationship with patients
- Relationship with colleagues
- Relationship with society
- Relationship with self - reflection on practice, identify strengths and weaknesses

Sir Donald Irvine, Chair, the Picker Institute Europe "*For individual doctors, embracing the new professionalism should bring them the greater peace of mind and self-confidence which comes from knowing they are respected by their patients and colleagues alike for being on top of the job, and are regarded as absolutely reliable and trustworthy.*

<u>Advocacy, communication and new elements of professionalism</u>

CPD should encompass new elements of professionalism, such as increasing needs for team working with colleagues and new challenges in communicating with patients and public. Surgeons are increasingly expected to help patients make decisions about what treatments to follow, rather than simply telling them what would be best. In a world of increasing political and managerial influence on the choice of care, surgeons are required more than ever to be advocates for their own patients and for groups of patients. Advocacy and communication skills can contribute positively to the doctor/patient relationship and the way the profession is perceived.

Dr Mike Watson, *"The medical profession has been left behind in changes in communication techniques… any senior person within medicine should be able to do media work, to get the message over appropriately."*

5.6 Appraisal, clinical audit, outcomes

Where appraisal is done well and properly resourced, appraisal is a valuable process and the key to successful CPD. By identifying opportunities to improve performance, relating this to a programme of learning activity and enabling reflection on the outcomes of CPD undertaken, appraisal facilitates a link between education and outcomes.

> Dr Mike Watson: *"Appraisal seems to be the only way of establishing a link between CPD and the appropriateness of training… It would not be unreasonable for the Colleges to say that one of their roles is to provide doctors with the tools and information to enable members to go to appraisal and get what is required from appraisal."*

The College should play a more important role in supporting appraisal and normalising best practice. *Good Surgical Practice* already provides a clear set of standards for the appraiser and appraisee to use. The College could strengthen the role it plays as mentor to fellows and members, for example, by developing good practice guides relating to appraisal and personal development, provision of online resources and regional support. The development of an e-portfolio system could also be used to support the appraisal process, both in directing CPD and ensuring appropriate reflection.

It is noted that the Academy of Medical Royal College is currently undertaking an assessment of the role it could play in supporting appraisal, through provision of guidance and supporting tools.

Clinical Audit

Taking part in regular clinical audit is part of good clinical and professional practise. Through appraisal, audit data can play an important role in directing and reflecting on CPD. For example:

- Identifying areas that might be improved through CPD activity.
- As a measure of the impact of CPD on surgical performance and patient outcomes.

Appraisal provides an opportunity to consider audit data within the framework of other outcomes, such as multi-source feedback. It also enables outcome data to be considered within the context of the surgeon's clinical workload, the complexity of operations they perform and the impact of the wider surgical team.

Outcomes

The main purpose of the College's CPD policy should be to facilitate surgeons to improve their performance and consequently improve patient experience and outcomes.

It is not usually possible to attribute change in clinical outcomes to a specific learning event. A range of factors can prevent the benefits of educational experience being applied in practice, including managerial resistance, lack of equipment, organisational structure.

Professor Janet Grant *"Of course you're interested in outcomes but you have to recognise that you can't measure the effect of a CPD event in terms of outcomes.*

However, there is evidence that continuing education can improve knowledge, skills, attitude, behaviour and health outcomes. In particular, strategies involving hands-on skill practice and interaction with faculty and other learners is an important educational strategy to promote change in behaviour.[13]

Within the context of appraisal, audit and other outcome data does provide an opportunity to reflect on the effectiveness of CPD in changing outcomes.

Dr Ian Starke, Director of CPD, Royal College of Physicians of London: *"Change in outcomes may not be attributable to the CPD but at the end of the day that doesn't matter too much to patients, as long as there is change and you can see where the CPD has happened."*

It is noted that the Academy of Medical Royal Colleges will shortly be undertaking research relating to measuring the impact of CPD by outcome assessments.

Recommendations
The end purpose of CPD should be to develop the professionalism of surgeons and improve patient outcomes. These ideals should be central to the College's CPD policy.

6. CONCLUSIONS

6.1 The Role of the College in CPD – standards and systems and provision of programmes

It is essential that the respective roles of the College and Specialist Associations are agreed at an early stage. The College should play an umbrella role, providing a framework for the associations to deliver their CPD policy, a framework for individual development and a framework to support Trusts in delivering the appraisal process. This umbrella role is likely to include responsibility for setting policy, recording CPD activity, accrediting courses and providing generic courses.

Standards

The College strategy on CPD should be to maintain professional standards and the reaffirmation of professionalism. The College has a key role as guardian of the clinical competence of its fellows and members, articulating the obligation to maintain professional standards and skills. As part of this role the College sets standards for surgery (*Good Surgical Practice*) that can be used to support the appraisal system and assist in identifying individual's educational needs. CPD should apply to all surgeons including SAS grade staff and consultants.

Miss Liz Symonds, Chair Patient Liaison Group, Royal College of Surgeons of England: *"SAS grade surgeons are as valuable and important as any other grade of surgeon and patients expect them to meet the same generic qualities."*

Systems

The College also plays a role in enabling Fellows and Members to gather evidence of CPD, currently through providing access to the Senate of Surgery proforma. Additional work would be necessary to develop an online CPD tool.

The support provided to Fellows and Members would need to be reviewed in light of any change to the College's CPD policy. Mentoring and supporting Fellows and Members to participate in CPD should be a priority for the College. This service could be enhanced by making tools available to assist surgeons in identifying their learning needs and in signposting to advice and support. The College could also provide guidance on other professional activities, such as the role of the clinical director.

Research

The College should support the ethos of surgeons undertaking research as part of their professional development and provide a voice in identifying research needed, such as quality of life post surgery.

Relationship with NHS Trusts

For an individual surgeon to meet their CPD needs and any requirements set by the College the support of their Trust, or other employer, is essential. Individual portfolios will be developed at local Trust level and the College will need to liaise with local Trusts to ensure any new system works effectively.

The College should advocate for the support necessary to enable surgeons to fulfil their CPD and other developmental objectives, including the need to protect study leave budgets. This could be achieved through setting guidelines relating to appraisal and the collection of clinical data.

Courses

An important part of the College's work is in developing and running clinical and professional development programmes to meet the learning needs identified by surgeons. The work of the Raven Department of Education at the College will remain central to the support provided to surgeons.

Links with specialist associations

The College should work closely with the specialist associations in the development of its CPD policy and should aspire to facilitating changes to Senate-wide CPD policy.

6.2 Key recommendations

1. The College should revise its CPD policy.

2. This revised policy should acknowledge the close link with appraisal.

3. The CPD policy should recognise that CPD is not a static activity and that surgeons' needs change over the course of their career.

4. The College's CPD policy should apply to all surgeons, including Staff and Associate Specialist (SAS) grade staff. This process could be based on a similar system to the Australasian College model, whereby non-fellows of the College are able to use the Maintenance of Professional Standards (MOPS) Programme in return for payment of a fee.

5. The end purpose of CPD should be to develop the professionalism of surgeons and improve patient outcomes.

6. In light of the *Good doctors, safer patients* the College should work towards the introduction of a compulsory system of CPD that will support the recertification process. The details of the system should take into account the work of the Academy of Medical Royal Colleges.

7. The College should establish a compulsory and quantifiable measure of CPD that will form part of the requirements for recertification, and review whether this can be achieved without reintroducing a points-based system.

8. The College should develop an online CPD portfolio, with appropriate support, that Fellows and Members can use to record their CPD and other activity linked to recertification.

9. The College should review the accreditation of courses in light of work of the recertification process developed in light of *Good doctors, safer patients*.

10. Reflection is an essential element of CPD and any online system developed to support CPD should include a compulsory section for reflection.

6.3 Actions and priorities

- A business plan for the development of a CPD system should be produced as a priority.

6.4 Conclusion

CPD is the College's future. It encompasses all aspects of a surgeon's life, and rightly focuses on the Fellow, the working surgeon. It offers lifelong support through motivation and leadership for surgeons to maintain and improve their professional standards for the benefit of their patients and the public.

Appendix 1 Membership of Working Party

The working party comprised the following: -

- Mr Chris Chilton - Member of Council (Chair)
- Francine Alexander – Professional Development Projects Manager, Raven Department of Education
- Mr Pragnesh Bhatt, SAS Committee representative
- Lavinia Blackett – Head of Professional Standards, Professional Standards & Regulation Division
- Mr Dave Clark – Policy Coordinator, Professional Standards & Regulation Division
- Dr Nick Cooper – GP & Senior Clinical Lecturer Education, Peninsula College of Medicine and Dentistry
- Miss Anne Moore –Vice President
- Elizabeth Symonds - Chair, Patient Liaison Group
- Professor Irving Taylor – Member of Council and Chair of Professional Standards Committee
- Mr Bill Thomas – Member of Council
- Professor Norman Williams – Member of Council

Appendix 2 Expert Witnesses

In order to take forward the development of CPD policy, a series of evidence gathering meetings were held over the summer of 2006. The follow professionals shared their expertise with the working party:

- Irene Borgardts – NHS Clinical Governance Support Scheme, Department of Health
- Ms Victoria Burt – CPD Manager, British Psychological Society
- Mr Harry Caton CBE - National Director for Patients and Public, Department of Health
- Professor Janet Grant – Professor of Education in Medicine, Open University
- Sir Donald Irvine - Chair, Picker Institute Europe
- Dr Murray Kopelow – Chief Executive, Accreditation Council for Continuing Medical Education (ACCME)
- Mr Michael Kuo – Chairman, Education and Training Committee, British Association of Otorhinolaryngologists: Head and Neck Surgeons (BOA – HNS)
- Mr Graham Layer - Chair, Joint Committee on CPD (JCCPD), Senate of Surgery
- Dr Malcolm Lewis – Member of Council General Medical Council and Director of Postgraduate Education for General Practice, School of Postgraduate Medical and Dental Education, Cardiff University.
- Dr Bernard Maillet - Secretary General, European Union of Medical Specialists & European Accreditation Council for Continuing Medical Education (UEMS EACCME)
- Dr Alastair Mason – Consultant Epidemiologist, National Centre for Health Outcomes Development
- Professor Richard Ramsden – President, British Association of Otorhinolaryngologists: Head and Neck Surgeons (BOA – HNS)
- Professor Jenny Simpson – Chief Executive, British Association of Medical Managers (BAMM)
- Dr Ian Starke – Director of CPD, Royal College of Physicians of London
- Dr Mike Watson - Chair of the Academy of Medical Royal Colleges Directors of Continuing Professional Development (DoCPD)

Appendix 3 - THE ACADEMY OF MEDICAL ROYAL COLLEGES
TEN PRINCIPLES FOR CONTINUING PROFESSIONAL DEVELOPMENT

1. An individual's CPD activities should reflect and be relevant to their profile of professional practice and performance. This should include continuing professional development outside narrower specialty interests.

2. CPD should include activities both within and outside the employing institution, where there is one, and a balance of learning methods which include a component of active learning. Participants will need to collect evidence to record this process, normally using a structured portfolio cataloguing the different activities. This portfolio will be available for appraisal and revalidation.

3. College/Faculty CPD schemes should be available to all members and fellows and, at reasonable cost, to non-members and fellows who practise in a relevant specialty.

4. Normally, credits given by Colleges/Faculties for CPD should be based on one credit equating to one hour of participation. The minimum required should be an average of 50 per year. Credits for un-timed activities such as writing, reading and e-learning should be justified by the participant or should be agreed between College/Faculty directors of CPD.

5. Participation in College/Faculty based CPD schemes should be acknowledged by a regular statement issued to participants based on annually submitted returns.

6. In order to quality assure their CPD system, Colleges/Faculties should fully audit participants' activities on a random basis. Such peer-based audit should verify that claimed activities have been undertaken and are appropriate. Participants will need to collect evidence to enable this process.

7. The proportion of participants involved in random audit each year should be of a size to give confidence that it is representative and will vary according to the number of participants in a given scheme.

8. Self-accreditation of relevant activities and documented reflective learning should be allowed and encouraged. Formal approval of the quality of educational activities for CPD by Colleges/Faculties should be achieved with the minimum bureaucracy and with complete reciprocity between Colleges/Faculties for all approved events.

9. Self-accreditation of events will require evidence. This may be produced as a brief reflective note. Formal CPD certificates of attendance at meetings will not be a requirement. Other evidence of attendance should be provided, as determined by each individual College or Faculty. Signed registers are only necessary where there is no other available evidence of attendance.

10. Failure when challenged to produce sufficient evidence to support claimed credits will result in an individual's annual statement being endorsed accordingly for the year involved and the individual subsequently being subject to audit annually for a defined period. Suspected falsification of evidence for claimed CPD activities may result in referral to the GMC/GDC.

Appendix 4 - Recommendations from *Good doctors, safer patients*

Recommendation 17 – A clear and unambiguous set of standards should be set for each area of specialist medical practice. This work should be undertaken by the Medical Royal Colleges and specialist associations, with the input of patient representatives, led by the Academy of Medical Royal Colleges.

Recommendation 26 – The process of revalidation will have two components: first, for all doctors, the renewal of a doctor's licence to practice and therefore their right to remain on the Medical Register (re-licence); secondly, for those doctors on the specialist or GPs registers, 're-certification' and the right to remain on these registers. The emphasis in both elements should be a positive affirmation of the doctor's entitlement to practice, not simply the apparent absence of concerns.

Recommendation 31 – Specialist certification should be renewed at regular intervals of no longer than five years. This process should rely upon membership of, or association with, the relevant medical Royal College, and renewal should be based upon a comprehensive assessment against the standards set by that college. Renewal of certification should be contingent upon the submission of a positive statement of assurance by that College. Independent scrutiny will be applied to the process of specialist re-certification operated, in order to ensure value for money.

Appendix 5 - Royal Australasian College of Surgeons, Summary of CPD Programme

All Fellows who are active in practice are required to participate in the 3-year CPD programme and to annually submit a data form recording their CPD totals. The requirements differ according to the type of practice. Fellows who meet the requirements of the programme receive a Certificate of Continuing Professional Development at the end of the 3 year period. Fellows also receive an annual participation statement. The current 3-year CPD programme ends in December 2006.

The triennial certificate is evidence of recertification of a fellow. The **requirements over the 3 year period** for all surgeons in hospitals or day surgery units are:

- Undertake a peer review surgical audit – annual requirement
- Be credentialed at an approved hospital – annual requirement
- Accrue 30 points from Category 3 (clinical governance and evaluation of care)
- Accrue 210 points from Categories 4-8 (maintenance of knowledge and skills), including attending at least one approved scientific meeting

These requirements are the same for full time and part time surgeons.

Fellows who have met the annual requirements receive a CPD Program Statement of Participation for 2005. Fellows who meet the requirements for the 2004-2006 CPD Program triennium will be issued the Certificate of Continuing Professional Development 2004-2006. The triennial certificate is evidence of recertification as a Fellow.

2.5% of Fellows are randomly selected annually for verification of their CPD data. Fellows selected for verification are asked to provide documentary evidence of their CPD activity.

Fellows who do not meet the annual requirements, who do not participate in the programme or who do not successfully verify in any one year will have their name forwarded to the Speciality Society for review and/or guidance. If a Fellow's CPD status remains unchanged following this review they will be notified of their non-compliance or non-participation in writing by the College President and will not be eligible for the Certificate of CPD.

Exemption

Fellows who are retired from all forms of medicine are not required to participate in the CPD programme. Exemption may also be granted in special circumstances due to:

- Fellows undertaking additional full time study in a relevant area
- Fellows residing overseas
- Ill health, family leave, or similar

Non Fellows

The Maintenance of Professional Standards (MOPS) program is available to surgeons who are vocationally registered in Australia and New Zealand, and who are not fellows of the College. Payment of an annual fee enables specialist surgeons to demonstrate that they are engaged in continuing professional development activities.

CPD Programme

Over a three year cycle CPD must include:

Category 1 – Surgical audit and Peer Review
All practicing surgeons are required to participate in an annual surgical audit, and to submit the audit for peer review. The activity can be:

- A personal surgical audit that complies with RACS guidelines
- Total/practice or workload audit – audit of all operations performed by an individual surgeon
- Selected audit from surgical practice – audit covering all patients undergoing a selected procedure
- Clinical unit audit
- Speciality group audit – audit conducted by a group or speciality society
- An audit approved by the Board of CPD and Standards – an audit using clinical indicators developed by RACS

There is a professional obligation by all surgeons to

- Know and record the outcomes of their treatment
- Compare the outcomes with performance data from colleagues, clinical literature and other institutions
- Review and examine any defects apparent from audit data, and adopt and implement strategies to prevent re-occurrence

Category 2 – Hospital credentialing
All surgeons engaged in surgical activity must be credentialed to an ACHS accredited hospital. Maintenance of standards are supervised by Credentials Committees and Appointment Committees within the individual health facility. A letter of appointment/reappointment should be used as evidence of credentialing.

Category 3 – Clinical Governance and Evaluation of Patient Care
All surgeons in current practice should be involved in ensuring the safe provision of pre-operative, operative and post operative management of patient and the maintenance of surgical standards. This can be achieved by participating in any activity that examines the clinical care of patients, activities attract 1 point per hour and can include clinical meetings focussed on patient care, meetings addressing systemic faults, or other activity to review surgical services. 30 points must be achieved over 3 years.

Categories 4-8 Maintenance of knowledge and skills
Surgeons are responsible for maintaining their skills, knowledge and competence in their area of practice and developments in clinical/medical science. 210 points must be achieved from Categories 4-8 over 3 years, through attendance at meetings, teaching and research research.

Category 4 - Maintenance of clinical knowledge and skills
During the triennium all surgeons should attend at least one approved scientific meeting. A list of approved scientific meetings can be found at the CPD web page, including RACS scientific meetings, specialist surgical society clinical meetings and international scientific meetings. Attendance at scientific meetings attracts 1 point per hour.

Other activities in Category Four can include: Patient feedback surveys (40 points), small group learning (5 pph), surgical or clinical attachment to a peer (20 points), participation in RACS surgical courses (1pph) and general activities such as journal reading and information through the internet (1pph, max 20 points per annum).

Category 5 – Teaching and examination
This can include: teaching on RACS courses (1pph + 4 points), supervision of surgical trainees (1pph, max 20 points per annum), development of educational material (1pph, max 40 points per annum), general teaching to trainees, etc (1 pph, max 20 points per annum) and presentation to surgical peers at a scientific meeting (10 points per presentation for the first presentation of a topic only).

Category 6 – Research and publication
Includes the publication of a medical book (50 points), a journal article book chapter (15 points), participation in a clinical trial (max 5 points per annum), acting as referee for a journal article (5 points per article) and participation in organised clinical research (1pph, max 30 points per annum).

Category 7 – Other professional development
This category includes participation in RACS professional development courses, such as: risk management, surgeons as teachers, surgeons as managers, surgeons as educators, expert witnesses, statistics for surgeons and participation for practice (1pph), participationi n other courses by recognised providers (1pph, max 40 points per annum) and volunteer services.

Category 8 – Medico legal workshops
Fellows who undertake medico legal work need to attend at least one approved medico legal workshop during the triennium.

Weighting
Some activities are weighted to reflect educational value and have higher point allocations per hour: e.g. participation in small group learning is valued at 5 points per hour, as opposed to attendance at courses which is valued at 1 point per hour.

Support provided to Fellows
The Department of Professional Development provides support to surgeons in all aspects of their professional life, promoting professional growth and improving workplace performance. The Department runs a variety of workshops and courses to support professional development:

- Mentoring in the Workplace
- Work/Life Balance
- Self Care
- Graduate Certificate in Business Administration
- Surgeons as Managers
- Communication Skills for Cancer Clinicians
- Dealing with Difficult Patients Masterclass
- Expert Witness workshop
- Interviewer Training
- Practice Management for Practice Managers
- Preparation for Practice
- Risk Management Foundation and Masterclass
- Surgeons as Educators
- Surgical Teachers Course
- Winding Down from Surgical Practice

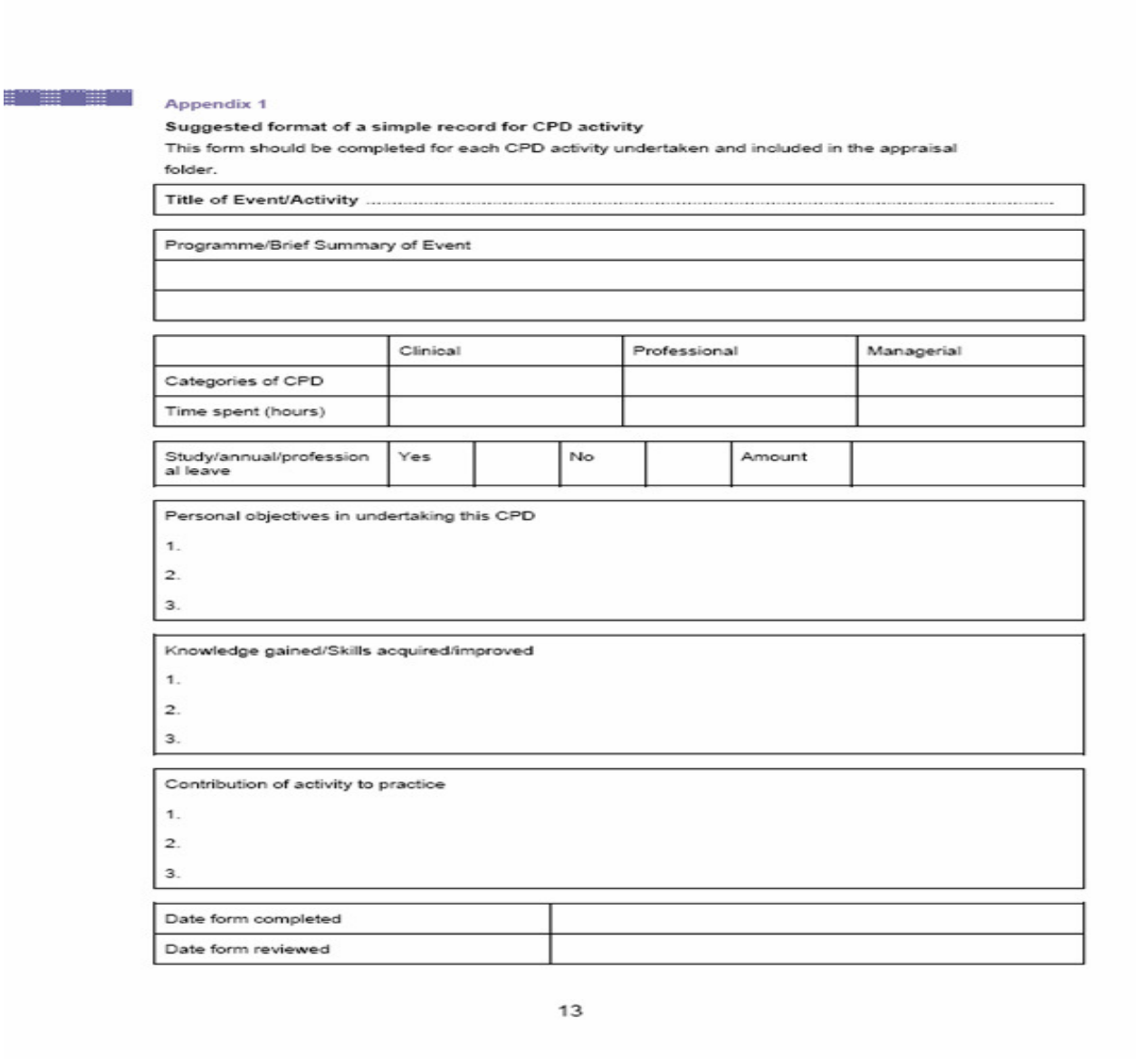
The Professional Development team also services the following committees and working parties:

- Surgeons as Educators Committee
- Younger Fellows Committee and Executive
- Medico Legal Section and Executive
- Senior Surgeons Fellowship Working Party

Other support includes:

- An online library, which includes full-text reference books and specialty journals
- Producing Guides and information to support the CPD process, including the Guide to small group learning
- A support scheme for Rural Specialists
- A Cross Cultural Communication Programme

Appendix 6 - Senate of Surgery Proforma for CPD



Appendix 1

Suggested format of a simple record for CPD activity

This form should be completed for each CPD activity undertaken and included in the appraisal folder.

Title of Event/Activity .....

Programme/Brief Summary of Event

	Clinical	Professional	Managerial
Categories of CPD			
Time spent (hours)			

Study/annual/profession al leave	Yes		No		Amount	

Personal objectives in undertaking this CPD
1.
2.
3.

Knowledge gained/Skills acquired/improved
1.
2.
3.

Contribution of activity to practice
1.
2.
3.

Date form completed	
Date form reviewed	

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[5] *The Shipman Inquiry: fifth report, safeguarding patients: lessons from the past, proposals for the future*, J Smith, The Shipman Inquiry, The Stationery Office, 2004
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[7] *Good doctors, safer patients*, Department of Health, July 2006.
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[9] *Continuing Professional Development*, General Medical Council, 2004
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[13] Robertson MK et al*, Impact Studies in Continuing Education for Health Professionals*: *update*, Journal of Continuing Education in the Health Professions, 23 p146-156, 2003.