***Consultation on revised CPD Registration standard***
**Response from Dr Peter Adkins, General Practitioner, Birkdale. Qld.**

**General questions**

**1. Is the content and structure of the draft revised CPD registration standard helpful, clear, relevant and more workable than the current standard?**

The significant focus on quality improvement activities based on performance and outcomes in the proposed standard is supported. It is useful to refer to **clinical** performance and **patient** outcomes in defining these the two areas.

The term Quality Improvement needs to be included alongside CPD as the overall objective is to improve the quality of care delivered. The fact that patient care is more and more delivered in teams and not by individual practitioners, and that the practitioner-patient relationship/partnership and funding/resources available determine clinical outcomes, is an important consideration in any proposal to measure patient outcomes with respect to improving the quality of care.

The removal of self-directed CPD from the standard is a retrograde step as one of the goals in continuing education and professional development is self-directed and lifelong learning. This omission also restricts choice in pursuing individual learning goals and overall motivation in learning.

Regarding workability, the proposed standard will significantly increase the practitioner time commitment for accredited CPD activities. This will be a particular problem for part time practitioners. The required number of hours in the new standard (50 hours per year, 150 hours over 3 years) is a significant increase on the number of hours currently undertaken by most general practitioners under the existing RACGP 130 points over 3 years standard. Based on my CPD statements for 2014-2016 (258 points and 91 hours of activity) and 2017-2019 (302 points and 82.5 hours of activity) the new standard will double my CPD time commitment over 3 years, and reduce the flexibility in completing CPD activities.

**2. Is there any content that needs to be changed or deleted in the draft revised standard?**

Regarding the proposal for a CPD Personal Plan, I would recommend the learnings from the introduction of the RACGP QI/CPD "Plan" in the 2017-2019 triennium (design and implementation) be considered. The RACGP Plan was heavily criticised by RACGP members as of limited value and not based on adult learning principles (e.g. Internal motivation, short term task orientated and practical learning).

If the medical board decides on removing self-directed learning as a CPD option then it makes less sense in requiring practitioners to develop a personal professional development plan as the CDP program will then be limited to available accredited CPD activities and not catering for individual learning needs.

It is important that CPD activities be measured/documented on their ability to improve knowledge, skills and attitudes and improve clinical performance and patient outcomes and not solely based on the number of hours participating in an activity. The number of hours is easy to measure, however is this the right measure?

**3. Is there anything missing that needs to be added to the draft revised standard?**

- Evaluation of the new standard – The draft revised registration standard proposes that the standard is reviewed every 5 years, however there is no detail on the methodology to determine whether the recommended Option 2 proposal is any better than the current CPD requirement in improving the quality of care generally across the profession and particularly in those practitioners where clinical performance has been identified as an issue.

- There is a need for all practitioners to have CPR skills and this requirement is missing from the standard as a requirement.

- There is a lack of clarity around consequences of not meeting the CPD standards for individual practitioners. A number of possibilities are outlined, however the process and consequences are poorly defined.

**4. Do you have any other comments on the draft revised CPD registration standard?**

The economic impact for practitioners, CPD homes and the medical board with the new proposed standard is briefly discussed outlined in Appendix A (Item D, p 49). To measure clinical performance rather than time spent in an educational activity is more costly for the individual practitioner, the CPD home and the medical board (audits). The cost of meeting CPD requirements under RACGP has almost doubled in the past 10 years. The rising cost to practitioners is a major concern and the overheads associated with CPD homes. The economic impact of the change needs to be studied in more detail ie a cost benefit analysis (costs vs desired outcomes in clinical performance and patient outcomes).

The minimum number of CPD hours (50hours per year) makes auditing the program easier, however the question is the right thing being measured (quality or quantity)?

**5. Who does the proposed registration standard apply to?**

Agree with the list of groups proposed in the new standard

**6. Interns**

Interns be exempted from CPD requirements given the fact that they are participating in a supervised hospital based post graduate training program, however Interns should be required to document their professional development activities in training. The “C” in CPD refers to Continuing Professional Development and not the initial post graduate training (vocational training).

**7. Specialist trainees**

Specialist trainees be exempted from CPD requirements given the fact that they are participating in a supervised hospital based post graduate training program, however specialist trainees should be required to document their professional development activities in training.

**9. Exemptions**

**a. Should exemptions be granted in relation to absence from practice of less than 12 months for parental leave, in addition to serious illness, bereavement or exceptional circumstances?**

Yes, exemptions should be granted

**b. Is 12 months an appropriate threshold?**

Yes, provided there is no requirement to meet a “catch up” requirement for the remaining 2 years of the CPD period.

**c. Should CPD homes grant these exemptions or should the Board?**

CPD homes to grant exemptions based on criteria/principles developed by the Board

**10. Practitioners with more than one scope of practice or more than one specialty**

**a. Do you agree with the Board's proposal that medical practitioners with more than one scope of practice or specialty are required to complete CPD for each of their scopes of practice/specialty and where possible this should occur within one CPD home? Do you have alternative suggestions?**

Flexibility in design is important with a focus in this care on CPD activities focus on clinical performance and patient outcomes across specialist areas, with less of a requirement on participation in educational activities. The assessment should be based on demonstration of quality care rather than the number of hours spent undertaking CPD i.e. quality not quantity.

**11. CPD required**
**a. Are the types and amounts of CPD requirements clear and relevant?**

The types of CPD are clearly outlined in the document. Practitioners need to be encouraged to develop and submit their own CPD activities for approval, rather than selecting off the shelf activities. Again the focus should be on demonstrating quality of care and not on the total number of hours spent undertaking CPD.

**b. Should all practitioners, including those in roles that do not include direct patient contact, be required to undertake activities focussed on measuring outcomes as well as activities focussed on reviewing performance and educational activities?**

It is reasonable to expect those practitioners involved in teaching medical students and post graduate practitioners to meet clinical performance standards and to be involved in patient outcome activities (e.g. research)

**c. If practitioners in roles that do not include direct patient contact are exempted from doing some of the types of CPD, how would the Board and/or CPD homes identify which roles/scopes of practice should be exempt and which activities they would be exempt from?**

There needs to be a level of flexibility in CPD homes to negotiate a suitable CPD/QI program for those practitioners who are involved in non-patient contact activities who will return to clinical care in the future. For those practitioners pursuing a non-clinical and non-teaching career, exemptions should be given.

**12. CPD homes**
**a. Is the requirement for all practitioners to participate in the CPD program of an accredited CPD home clear and workable?**

Yes, also provides the opportunity for increased competition in the CPD space

**b. Are the principles for CPD homes helpful, clear, relevant and workable?**

Yes

**c. Should the reporting of compliance be made by CPD homes on an annual basis or on another frequency?**

Depends what the consequence of this is to individual practitioners or CPD homes. This is discussed as a possible consequence, but not a clearly defined result of non-compliance. The existing standard for GPs allows a 3 year period for meeting CPD/QI standard. The new standard indicated a yearly requirement.

**d. Is six months after the year's end feasible for CPD homes to provide a report to the Board on the compliance of participants with their CPD program(s)?**

Depends what the consequence of this is to individual practitioners (see above)

**e. Should the required minimum number of audits CPD homes must conduct each year be set at five percent or some other percentage?**

This would depend more on the quality of the CPD provider activity and their application to a CPD home accredited activity. Auditing practitioner CDP statements would make less sense in the level of detail provided.

**f. What would be the appropriate action for CPD homes to take if participants failed to meet their program requirements?**

Depends what the consequence of this is to individual practitioners (see above)

**13. High level requirements for CPD programs**
**a. Should the high-level requirements for CPD in each scope of practice be set by the relevant specialist colleges?**

Yes

**14. Transition arrangements**
**a. What is a reasonable period to enable transition to the new arrangements?**
3 years

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