Quality of CPD in Dentistry

Faculty of General Dental Practice (UK)

Response to the GDC call for information

July 2013

Introduction

The FGDP(UK) very much welcomes the opportunity to comment on this review. We have long recognised that the undertaking of CPD is essential to raising standards, and CPD submission was a prerequisite for continuing FGDP(UK) membership at the inception of the Faculty 21 years ago.

In previous consultation submissions to the GDC, the FGDP(UK) has urged a move towards an outcomes-based approach to CPD, which we believe would allow for improved quality assurance within the process. It is also clear that there is a lack of consistency among CPD providers with regard to robust quality control processes, and we feel that there is a need for guidance on what defines adequate quality control.

Clearly, the ultimate measure of CPD quality is how it translates to the registrant's practice and the impact that it has on the standard of patient care. This is difficult to measure, but does highlight the need to assess CPD quality both via short- and longer-term mechanisms. For instance, it is likely that the cumulative effects of engaging in consistently poor CPD is only likely to manifest itself after a period of time. We would suggest that CPD can only have meaningful value when it is linked to a nationally consistent framework of appraisal that can provide an assessment of impact on patient care.

Response

1. What is your involvement and experience of CPD in dentistry, and in what capacity?

The FGDP(UK) provides, assesses and accredits CPD for all members of the dental team. Our CPD provision is via a number of routes: our quarterly publication *Primary Dental Journal*; through events and study days; through completion of the key skills e-learning program; through the key skills assessment for DCPs; and, via participation on our short courses. We assess CPD as part of portfolios of evidence submitted as required for successful completion of our various courses, and we have accredited CPD for participants on the FGDP(UK)'s Career Pathway (now the Professional Development Pathway). Many of our members, including Board members, also provide CPD through their work with other bodies such as the postgraduate deaneries, universities and dental education companies.

The FGDP(UK) was also responsible for the production of the report '*The Impact of Continuing Professional Development in Dentistry: a Literature Review'*, commissioned by the GDC to inform work as part of the wider review in this area.

2. From your experience, what methods of quality control in CPD in dentistry are in place?

We would wish to understand more clearly how the GDC would define 'quality control' in this context. In its consultation on its quality assurance framework in 2007[1], PMETB (now merged with the GMC) set out definitions for quality assurance, quality management and quality control, which may be useful to consider in relation to this review. This document describes a definition of quality control as 'the procedures and organisation within education providers to ensure that the education and training received meets local, national and professional standards'. In this case, the postgraduate deaneries have accountability for managing overall quality and are responsible to the regulator for maintaining/improving standards of training over time.

We would view quality control as referring to a set of processes to ensure that a defined level of quality is reached during the production and delivery of a service. Currently, there is no definition within dentistry as to what is regarded as an 'acceptable' quality standard for CPD, therefore where processes and arrangements do exist, there is little way of gauging their effectiveness, not least in terms of impact on patient care outcomes. For example, at a basic level, would one individual in ten who gained little from a CPD experience be regarded as acceptable? Also, in taking a broader view, we should consider the validity of CPD awarded where feedback has indicated that few or no participants gained any educational value from the CPD.

While the quality control arrangements could be considered to be generally sound for CPD gained through studying for formal qualifications (eg, through a college/university or faculty of a royal college), there may be little or no such arrangements in place for CPD gained, for example, by reading an article in a journal.

All courses and events delivered by the FGDP(UK), along with those offered by the deaneries and other professional bodies, have stated aims, objectives and outcomes, and speakers must adhere to these while ensuring that each aspect of the education delivered is evidence-based. Quality is assessed by an appropriate participant feedback instrument along with verbal feedback on educational content from both participants and tutors. Course evaluations are fed back to lecturers and poor performance will influence future engagement with the lecturer.

Overall, we would suggest that currently there are limited quality control arrangements in place for CPD in dentistry. While the GDC makes clear the need for quality control in order for CPD to be considered as verifiable, we have no way of knowing at present if providers have such a system in place and, if they do, whether it could be considered 'adequate'. Certainly, there appears to be a dearth of stated educational objectives and demonstrable outcomes with respect to much of the online CPD that is available to the profession[1], which is particularly concerning given the ease of access to this source. Also of considerable

[1] An example of good quality online CPD is e-Den, the online interactive learning resource developed by e-Learning for Healthcare, the FGDP(UK) and the Faculty of Dental Surgery RCSEng.

concern to us is the apparent low 'pass' threshold and the random 'box ticking' that appears to be a feature of some online CPD available[2].

It is clear that providers, and therefore the profession, would benefit from having a clear definition of what constitutes adequate quality control, as well as clear guidelines on appropriate pass/fail thresholds where these exist (such as online journal CPD) and the level at which the educational value of CPD should be set. There may also be value in having better guidance for providers on how to structure and manage participant feedback so that it provides the best possible benefit. For instance, in relation to a CPD event or course, it may be useful for both providers and participants to gather/provide feedback following a period of reflection, in addition to immediately after the learning experience, and for this to be integral to the course design. Also, greater probity could be achieved by placing an obligation on providers to publish feedback so that it may be viewed by previous and prospective participants, other providers, standard setting bodies and other stakeholders, with standard templates provided by the GDC for this purpose.

3. From your experience, what methods of quality control of CPD in dentistry do you believe are most effective at ensuring adequate quality provision?

It is difficult to answer this question without a clear definition of what represents 'adequate' quality. At present, provider-driven quality control of CPD is largely reliant on the ethics and professionalism of the provider and is therefore likely to be highly variable. Conscientious providers ensure that speakers have the requisite expertise and can demonstrate competency as a dental educator. In addition to the latter, some providers (including the FGDP(UK)), use immediate course feedback for taught programmes, though we recognise that this is only one output measure and, as such, carries limitations. For instance, immediate feedback cannot gauge the impact of the learning following a period of reflection. In our view, although participant feedback is often a good method of quality control, it may be that a combination of several measures is needed to ensure quality provision.

One could argue that only through accreditation of CPD by an independent body could we have sufficient confidence that the CPD is structured to meet the learning needs of the practitioner and importantly, can have a positive impact on patient care. Currently, there is no established framework of accreditation, and this could be considered necessary going forward. Deanery approval can provide a level of quality assurance for CPD delivered in a given region at present, although standards may vary among deaneries, particularly in the absence of any universal framework. A formal system of independent accreditation would assess the aims, objectives and educational content of CPD and monitor feedback to ensure that these are met, and could involve standard-setting bodies such as universities and/or royal colleges.

The GDC may wish to consider a system of quality assurance that is designed to mitigate against the risks that have the greatest impact on patient safety. For instance, it may be considered necessary to have an approval process in place for CPD in areas such as implant dentistry, but not in areas such as practice management for example (without devaluing the importance of the latter to the delivery of effective patient care). A cost benefit analysis of any new quality assurance measures would be essential to ensure that the profession is not burdened with costs associated with any such system.

Until a system of accreditation/quality assurance has been established, registrants should be reminded of their responsibility to ensure that CPD activities are effective and relevant to their learning needs.

4. Based on your experience of verifiable CPD in dentistry, how assured or concerned are you about the adequacy of quality control of CPD?

In our view, most CPD provided by recognised academic and educational establishments has adequate quality control mechanisms in place, especially those approved via deaneries, the faculties of the royal colleges, and other teaching centres. However, provision of dental CPD is now big business with many unregulated private providers who, it is suggested, may not have adequate (or any) mechanisms for quality control. This is of particular concern with some online CPD and passive CPD such as reading journals (where this is verifiable), as outlined earlier.

5. In general terms, what experience do you have of the provision of verifiable CPD not being of adequate quality in your opinion?

The FGDP(UK)'s Credit Transfer Committee assesses the qualities of education undertaken by participants on the Faculty's Career Pathway (now the Professional Development Pathway). As part of this work, the Committee has identified areas where quality was considered to be inadequate according to Faculty standards, although the majority of submissions gave rise to no concerns. While the number of cases considered by the Committee may not be representative of CPD Courses as a whole, the GDC may find the processes used by this Committee of value when taking the present work forward.

General courses covering basic topics, including core CPD as defined by GDC, are often of acceptable quality and provide valuable educational experience for the purposes of updating knowledge and ensuring patient safety. However, the experience of some Faculty Board members, as registrants, reflects a range of concerns around the quality of some verifiable CPD, including attendance at events with questionable educational value or outcomes, or the lack of reflective thinking required to gain CPD from online or paper-based sources. Significant concerns exist where a course purports to deliver CPD that may be considered by the participant as providing sufficient skills and knowledge to undertake new treatment procedures, for instance, a weekend course teaching the 'essentials' on implant dentistry. In these cases, the learning objectives and outcomes of the course may lead to inadequate standards of patient care, or even patient safety issues.

6. What is your belief about the consequences of CPD that is of inadequate quality?

As above, the Faculty has concerns that, in some cases, inadequate CPD courses leave participants with the perception of having gained the skills and knowledge in a clinical discipline that is necessary to provide a particular type of treatment to patients. As a matter of priority, we consider it essential for the GDC to have in place a requirement for appropriate peer assessment of skills in treatment areas that may carry significant risks for patients. At a basic level, we would suggest a categorisation of CPD courses as didactic or practical skills development

The Faculty would also stress the importance of peer review or appraisal as one benchmark of CPD quality, and we would highlight the risks of gaining the majority of CPD at home or from a single source (eg, online or journals). There are also consequences for the profession in terms of value for money and time management from poor quality CPD, and the possibility that registrants are being accredited for CPD that is

of limited value to their learning needs and to patient care. Ultimately, it is the very validity of registration, and therefore public assurance in the profession, that is at risk from CPD of insufficient quality standards.

7. What suggestions do you have about how the quality of CPD in dentistry can be adequately assured?

As set out earlier, the FGDP(UK) would urge that a risk-based approach is taken, where the CPD activity is weighed against the implications of successful completion. For example, a diploma in a clinical domain may lead to the holder undertaking activities of considerably greater risk to patients than a day course in which knowledge alone was provided. For the former, we would argue that the level of adequacy needs to be greater than for the latter.

Clear guidance needs to indicate how providers can ensure that CPD is fit for purpose (ie, with appropriate aims, objectives and outcomes), and also fit for the person, ie, how it meets the needs of the registrant as defined in their personal development plan; in addition, support should be in place (eg, via appropriate bodies such as royal colleges, the deaneries and/or teaching hospitals) to assist with the development of PDPs for those who do not have one. The FGDP(UK) contributed towards the development of COPDEND's Standards for Dental Educators[3], which provides excellent guidance for education providers and would be a helpful resource as part of this review.

The quality of CPD can only be determined if accredited by an independent standard-setting body with an appropriate framework for quality assurance, similar to that in place within undergraduate and some postgraduate education providers. This needs to be balanced against the risks of creating a bureaucratic and expensive system which may generate a barrier to accessing good quality CPD for some registrants such as dental care professionals. For those types of CPD that could be considered as having significant implications for patient safety, a system of quality assurance could, for example, be based on random checking by the GDC, which would provide the necessary incentive but without the expense associated with universal checks.

References

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3 http://www.copdend.org/data/files/Downloads/COPDEND_Standards%20high%20resolution.pdf Published February 2013.

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