General
Dental
Council

Shaping the Direction of Lifelong Learning for Dental Professionals

Discussion Document Outcome Report

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1. Executive summary

In 2019, the General Dental Council (GDC) published a discussion document to invite ideas, comments and views on the future development of lifelong learning, or continuous professional development (CPD), in dentistry. The purpose was to gather views of dental professionals and other stakeholders on a future model for lifelong learning, on CPD practices and activities that might form part of a future portfolio model, and on how CPD topics are to be chosen. The document was informed by a systematic literature review, our CPD advisory group, two stakeholder workshops, and feedback to the initial CPD proposals set out in Shifting the balance in 2017. This report presents the outcomes of the questions we asked in that discussion document.

We received a total of 117 responses to our discussion document with 102 coming from individuals and 15 from stakeholder organisations. The responses showed that overall, there was strong support for GDC's proposed direction for lifelong learning, particularly the move towards a professionally owned, self-directed model. However, some did raise concerns about practicalities of the proposed model, such as associated costs, access to certain activities, time off work, and how compliance would be achieved. In reference to the proposed portfolio model, there was a general positive consensus on what the components of the model should be. Active learning, one of the proposed components, gained the most support whilst peer and mentor/coach interaction gained the least agreement. Notwithstanding the overall support for the portfolio components, there were concerns raised about how this kind of model would be monitored, with some feeling that more detail from the GDC was required.

There was a divided opinion about the possible impact of removal of the minimum hourly requirements, if such a change were to be adopted in a future system. Some respondents said that removing the requirements could make the system more flexible, meaningful, and better tailored to their needs and field of practice whilst reducing the appeal of lower quality CPD. However, others commented that retaining the minimum hourly requirement was important to ensure that professionals carried out a certain amount of learning. A significant number of respondents raised concerns that a system with more freedom and flexibility might mean that some professionals will inevitably "cheat the system" or only do the bare minimum.

Opinion was also divided on the possible impact of the removal of recommended topics. While most individual respondents agreed that recommended topics had a positive impact on CPD choices, a large majority also agreed that completing recommended topics was a 'tick-box' exercise. When asked where the responsibility lay for driving CPD activities and recommended topics for dental professionals, individuals and stakeholders all suggested that a range of organisations had a role to play in influencing CPD choices and that this should not be solely within the GDC's domain.

Incentives such as time off, free CPD, or a discounted ARF were common responses for how to motivate professionals to adopt positive but non-compulsory changes into their practice. Some stakeholders, however, commented that a cultural shift was needed to change attitudes amongst professionals so that their CPD is appropriately tailored to their field of practice. Additionally, some suggested that having a system which was easy to use, based online and reduced the burden of paperwork for professionals, would help professionals to adopt a portfolio model.

Whatever the changes that are needed to be made, stakeholders stressed the importance of a wide-ranging outreach programme to inform and engage affected parties prior to changes taking place.

We thank all respondents for their views, comments, and insights. Our next step in developing a new model for lifelong learning is to complete a comprehensive evaluation of the current CPD scheme, which was called for by many of those who responded to the discussion document. This will seek to determine whether and to what extent the enhanced CPD scheme has delivered the outcomes it was designed to deliver.

This evaluation, alongside the feedback received on our discussion document, will form the basis for our proposals for revisions to how the expectations for lifelong learning are reflected by the GDC within a future scheme.

2. Responses to the discussion document

The discussion document presented a total of 26 questions with 10 in 'Part 1: A future model for lifelong learning', 11 in 'Part 2: CPD practices', and five in 'Part 3: Informing CPD choices'. In total, we received 117 responses:

- 112 via survey and five via email
- 102 survey responses from individuals
- 15 organisations in total – 10 responses via survey and five responded by email

A summary of the responses received from individuals and stakeholder organisations for each of the questions are presented below.

The organisations submitting responses to the discussion document were:

- Association of Dental Groups (ADG)
- British Dental Association (BDA)
- Council of Postgraduate Dental Deans and Directors (COPDEND)
- Dental Technicians Association (DTA)
- Combined response from Dental Professionals Alliance (DPA) and Society of British Dental Nurses (SBDN)
- Health Education England (HEE)
- Medical and Dental Defence Union of Scotland (MDDUS)
- NHS Education for Scotland (NES)
- Orthodontic Technicians Association (OTA)
- Royal College of Physicians and Surgeons Glasgow (RCPSG)
- Rodericks Dental (RD)
- SimplyHealth Professionals (SHP)
- Thames Valley and Wessex Postgraduate Deanery (TVWPGD)
- UCL Eastman Dental Institute (UCLE).

NB: All graphs in this report reflect responses from individuals only. All organisations, whether they completed the survey or provided an email response, have a separate analysis which provides a narrative summary of responses.

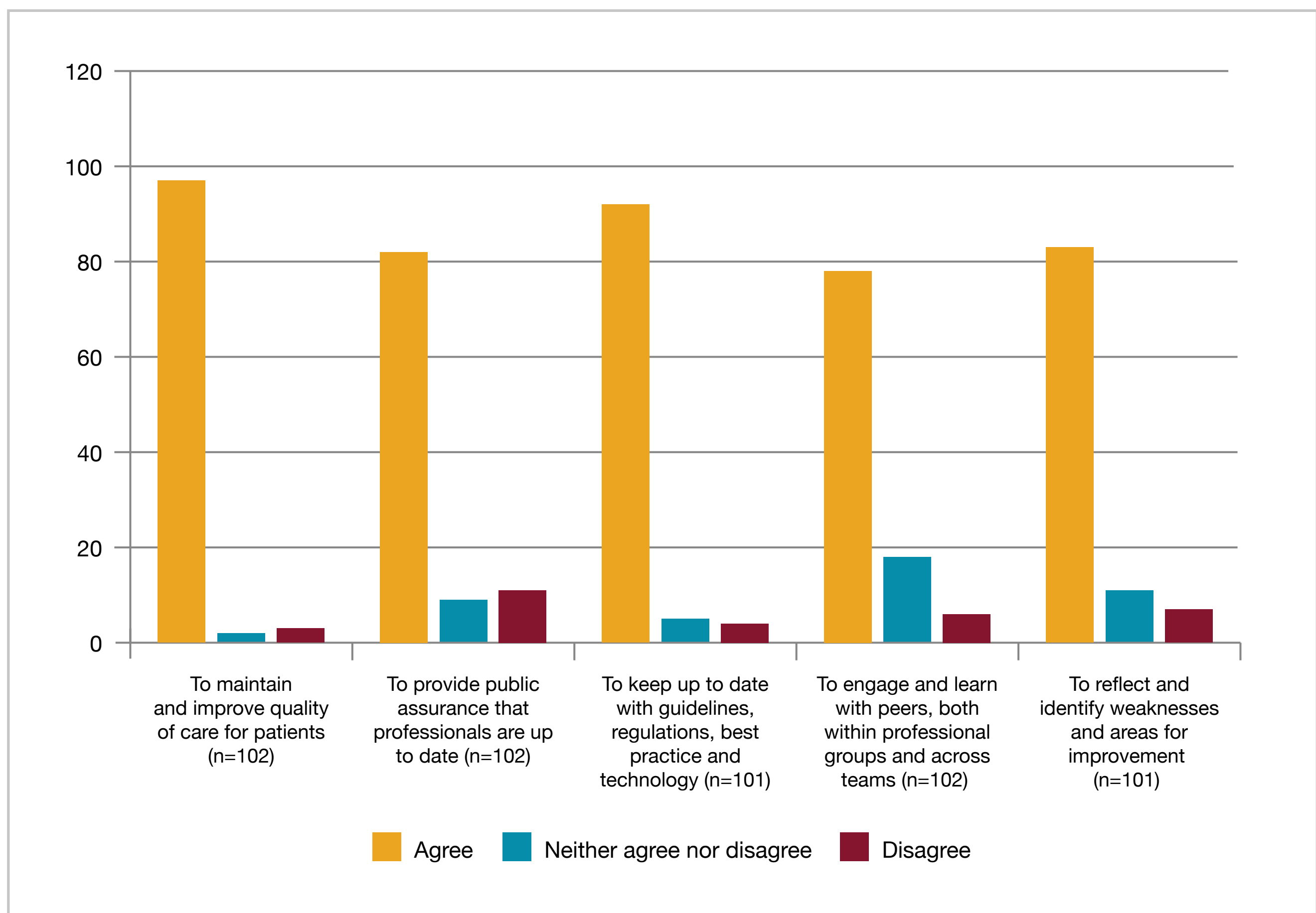
Part 1: A future model for lifelong learning

Q1: Do you agree with the statements describing the 'purpose of lifelong learning'? Individuals

Respondents were asked to what extent do they agree or disagree with the following statements describing the 'purpose of lifelong learning':

1. To maintain and improve quality of care for patients.
2. To provide public assurance that professionals are up to date.
3. To keep up to date with guidelines, regulations, best practice and technology.
4. To engage and learn with peers, both within professional groups and across teams.
5. To reflect and identify weaknesses and areas for improvement.

Figure 1: Purpose of lifelong learning



As the graph above shows, most individual respondents have either agreed or strongly agreed with all the statements. The first statement prompted the strongest agreement. The fourth statement, whilst still attracting strong agreement, recorded the largest proportion of undecided respondents. The second statement yielded the highest proportion of those in disagreement or strong disagreement.

Q1 (second part): Is there anything you would add?

Individuals

Of the 102 individual respondents, 65 made no comment on this question and 12 responded to say they had nothing to add. Seven respondents provided wording that broadly represented components of the above list.

There were various suggestions that emerged from the responses, the most popular being that relevance to individual roles must be considered, examples included non-clinical, academic or specialist roles. Other suggestions centred around the idea that lifelong learning should be more aspirational i.e. it should link to career progression, expanding skills and scope, and be used to motivate staff. Two respondents suggested that lifelong learning should be linked to the Standards for the Dental Team, and in particular Principle 1 - Put patients' interests first. Another respondent reflected that CPD availability is often driven by business interests rather than the evidence base. One respondent said lifelong learning should encourage learning across the wider healthcare sector, not just dentistry.

Organisations

All 15 organisations agreed or strongly agreed with the list of aims set out in Q1, and of these, three offered no further comments.

The additional comments received were wide-ranging. RD said the Personal Development Plan (PDP) would ultimately drive the aims of lifelong learning. The ADG suggested that lifelong learning should provide a degree of standardisation amongst colleagues. The BDA, DTA, and HEE emphasised the importance of CPD in gaining new skills and aiding career development, with HEE suggesting that the main aim of CPD should be to "further develop skills as a dental professional". UCLE said that there should be a greater emphasis on relevance to field of practice. Both HEE and UCLE suggested that the word 'weaknesses' should be replaced by 'areas for improvement'. NES stated that patient safety was key. MDDUS focussed their comments on the development of new graduates. COPDEND said that it was important for lifelong learning "to encourage sharing and learning from good practice, good outcomes".

Our response:

It is helpful to see that there is a strong consensus about the purpose of lifelong learning, which provides a good foundation to explore future developments. The positive and motivational link between CPD and career progression and scope/skills development has been noted and is an area that the GDC can help further enable working with others in the dental sector. The identification of CPD that is best for an individual forms a central component of the portfolio model. Other drivers, such as undertaking CPD for business interests (which can also align with patient interest) will need further exploration as we take this work to the next stage.

Q2: What more could be done to encourage professionals to undertake CPD activities that will meet the aims listed at Q1? Who has a role to play in this and why?

Individuals

A total of 81 individuals responded to this question and a variety of themes emerged. Most prominently, over a quarter of respondents reported that there were issues with provision of appropriate CPD. Comments associated with this view included improving access to CPD across the UK, variety and volume of CPD, and its quality. A small number of respondents told us that the CPD provided should be more rigorously evidence-based and quality-assured. For others, greater variety in the kind of activity available was desired, with various respondents referencing peer learning activities as important. Some comments suggested that professionals could select better or more appropriate CPD if it was linked with appraisal or supported by mentors.

Respondents said that in addition to the GDC, others with a role to play in improving CPD selection were CPD providers, deaneries, education and training providers, and employers.

An equally prominent theme was financial incentives and funding for CPD. Some argued that free CPD would encourage professionals, as the high costs involved for some activities were prohibitive. Others suggested that protected time from work was key, enabled by both the NHS contract and employers, and that in addition to the GDC, others with a role to play in securing this were HEE, NES and health boards.

The number of respondents who called for a more rigid system was only slightly lower than the number who called for a less strict or more flexible system. An individual who thought a more rigid system was needed suggested that the GDC could go as far as introducing compulsory CPD topics annually, while others called for a more stringent audit system. Conversely, those who commented that the system needed to be more flexible argued that the verifiable criteria were too strict, that the recommended topics (referenced by many respondents as 'compulsory' or 'core' topics) forced professionals into specific and narrow choices, and that there was sufficient regulation already in place.

Minor themes identified by respondents included the need for a cultural change amongst the professions, with several respondents stating that there was a divide in the profession, where "some always do the right thing", and others "look for a shortcut". Some suggested that education and training programmes should embed positive behaviours, and that employers had a role in encouraging their employees to adopt a professional approach. A small number of respondents called for the introduction of revalidation, similar to medical doctors, nurses and midwives[1].

Organisations

The 14 organisations that answered this question addressed similar themes to those received from individuals. The SBDN/DPA, UCLE, OTA and MDDUS shared common sentiments around the need for a cultural shift, where professionals were enabled to engage in lifelong learning, and where the focus moved away from a "punitive tick box approach".

1. Revalidation is a process by which professional regulators confirm the skills and abilities of a healthcare professional and continuation of their license to practise.

As with the individual responses, the issue of protected time and incentivisation was mentioned by ADG, COPDEND, NES, RCPSG and the BDA. The OTA and UCLE said that more could be done about the quality of CPD, whilst COPDEND stressed the importance of linking CPD with an appraisal system. The DTA commented that training pathways would encourage DCPs to undertake more quality CPD. HEE suggested that peer review process should be made a requirement in the development of a PDP. SHP and the ADG argued that employers had a role to play within the system. The SBDN/DPA expressed the view that some aspects of the current CPD scheme were too restrictive.

The DTA and the BDA identified that, as professional bodies, they had a role to play in encouraging professionals to undertake high quality CPD relevant to their field of practice. As was heard from individual respondents, organisations suggested that in addition to the GDC, others with a role to play in this were deaneries, HEE, Public Health England, dental schools and Royal Colleges.

Our response:

The question of whether the GDC should provide stricter and tighter rules around CPD activity and policing compliance or whether greater trust should be placed in professionals to do the right and best thing for themselves ran throughout the responses received. From these responses, it is apparent that finding a future model that satisfies a large majority of professionals will be challenging.

We have heard that moving to a system that places greater emphasis on the quality of activity and professional autonomy than on counting the hours spent would require a cultural shift. This is repeated in feedback given in response Question 4, below.

Our proposal is that professionals identify and undertake activities that are going to provide the best development for them and better care for their patients. The feedback indicated that using appraisal and support systems could play a greater role in this area, by identifying the right CPD for individuals to undertake.

We have heard that the barriers of availability, quality and cost of CDP can get in the way of accessing the right development. While these may be out of the direct control of the GDC, we will consider how we can work with other organisations to better address these. This could include some allowance for CPD that is more informal in nature, such as a peer review and reflective learning.

Q3 (first part): **To what extent do you agree that the components listed below are right for a future portfolio model?**

Individuals

Respondents were asked to what extent they agreed or disagreed with the following components being included in a portfolio model:

- Professionals maintain a 'portfolio' which is centred in a Personal Development Plan (PDP), owned and driven by the individual, who selects activities that best match their learning needs and field(s) of practice.
- Reflection and reflective practice.
- Active learning.
- Peer and mentor or coach interaction and feedback.
- Integrated team-based learning
- Assurance for the regulator that professionals are meeting the requirements.

Figure 2: Components of a future portfolio model

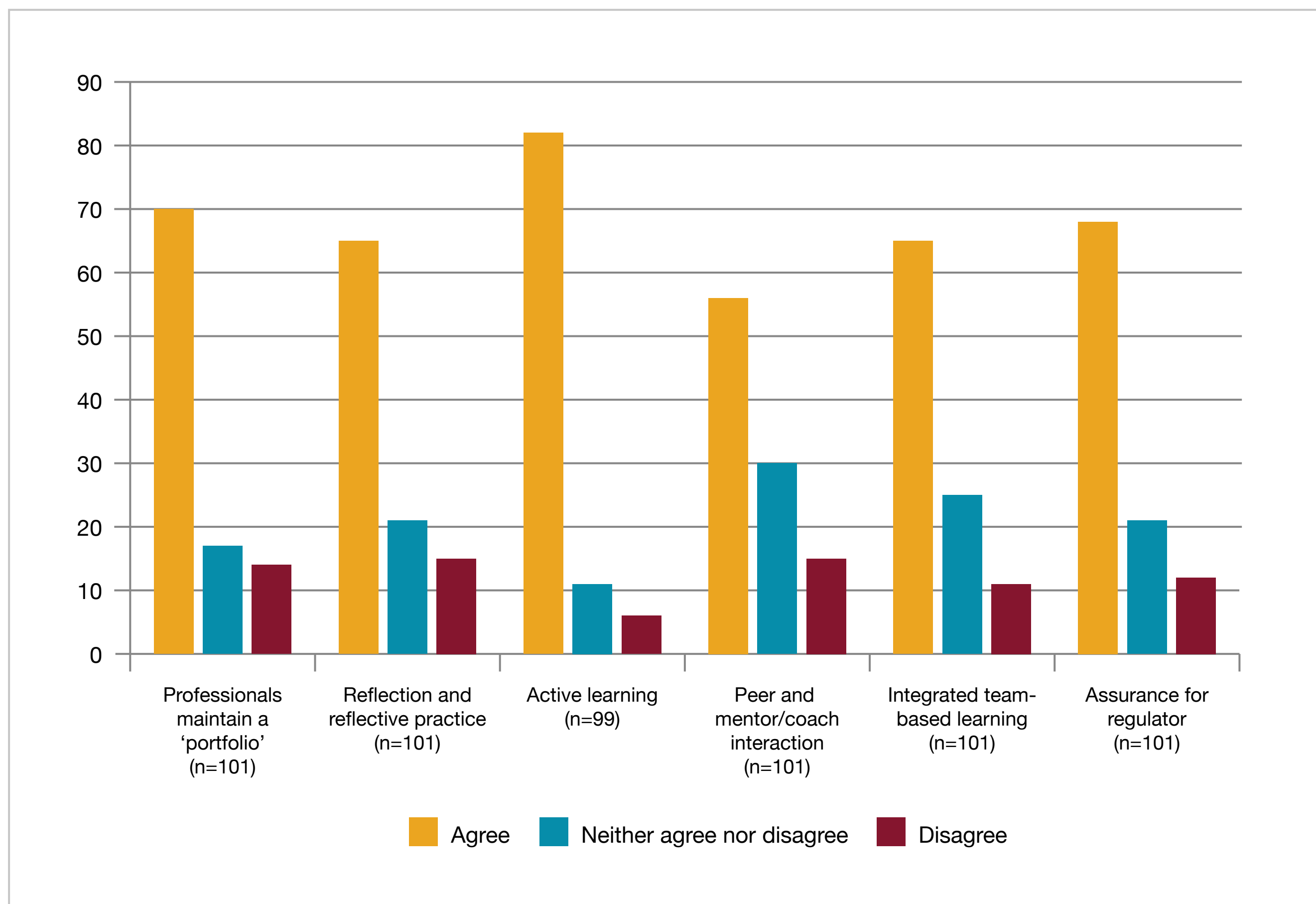


Figure 2 shows that all components produced over 50% agreement for inclusion in a portfolio model. Active learning produced the most agreement, with reflection and reflective practice, and peer and mentor or coach interaction gaining the least agreement, with the latter component also having the largest proportion not recording a view either way.

Q3 (second part): Is there anything you would add or remove from the list above?

Individuals

A total of 58 individuals responded to this question, 15 of whom responded "no" without commentary. Of those who provided a narrative response, approximately half commented on a specific component, whilst the other half provided more general commentary.

Those commenting on the requirement to maintain a portfolio argued that this may not be achievable in isolation, with professionals needing support and guidance to meet this. One individual raised a concern about the time this would require, which may affect willingness, and another proposed that mandatory training should be incorporated. Another individual stressed the importance of a portfolio designed to fit with learning-needs rather than to fit with the learning available.

On reflective practice, several comments suggested that this was most effective when kept informal, carried out in groups, and with record keeping minimised.

The 'peer and mentor/coach interaction and feedback' component yielded the most comments, with respondents reflecting on the demise of some peer review schemes, possibly as an unintended consequence of the GDC removing the regulatory requirement to report non-verifiable CPD. Some said that funding was needed to reintroduce it, with others commenting that to gain benefit from peer learning there was a need for training and/or to involve experienced facilitators. Some argued that barriers such as accessibility, availability and geography prevented access to peer learning.

Team-based learning raised comments from a small number of individuals, notably that it is not a suitable activity for all professionals, given the variety of clinical and non-clinical roles, and the range of workplace settings.

Regarding the last component, 'assurance for the regulator that professionals are meeting requirements', one individual questioned the practicality of this and argued that more detail was needed. Another stated it would be a "meaningless exercise" without an assessment. Another individual proposed that a formalised appraisal would provide assurance to the GDC that learning was occurring in a way that was positive and supportive to the professional.

Those who provided general comments mostly focussed on concerns about the potential cost, time and bureaucratic implications of the portfolio model. Two Dental Technicians raised concerns over the relevance to their role, particularly given their limited contact with patients, whilst a Dental Hygienist stated that support from the wider dental team and employers was crucial to the success of the portfolio model. One individual suggested that self-directed learning was also an important component of a portfolio model.

A small number of individuals raised concerns about these CPD activities becoming mandatory and argued that professionals could find themselves with an increased burden. Conversely, a further small number of respondents said that for these components to be successful, mandatory requirements would be needed.

Organisations

Two organisations, SHP and the DTA, said there was nothing to add or remove from the list of components that could make up a portfolio model. NES and MDDUS agreed with a portfolio approach, whilst the RCPSG said the components were appropriate but noted that some salaried dental professionals already

had a portfolio, and repetition should be avoided. The SBDN/DPA reported a mixed response from their members, who were unable to reach consensus about a portfolio approach. However, they stressed the need for significant guidance and support if such a model was introduced. The OTA disagreed with a portfolio model, expressing concerns about the potentially formal nature of a portfolio model, which could reduce flexibility and increase bureaucracy. The OTA stressed the benefits of professionals having the freedom to choose their own CPD, based on their individual learning and development needs.

Other organisations were undecided about whether they supported a portfolio model, raising concerns about some components. RD stated that reference to career pathways should be included, and HEE argued that the emphasis should go beyond clinical development to include communication, leadership, and management skills. COPDEND raised appraisals as the means of a portfolio being used effectively.

UCLE commented that the portfolio model may not suit the needs of every member of the dental team, and the DTA cautioned against adopting a hierarchical approach for different members of the team. The BDA queried the terminology around peer learning, mentoring, and coaching, and suggested these needed clear definition with more detail within the proposals including how they would be enforced.

Six of the 15 organisations provided comments about how the regulator could be assured that CPD had been completed. The ADG and the BDA argued that a portfolio, along with a PDP, should be private documents. The BDA along with the RCPSG cautioned against 'policing' reflection elements. NES said it was unsure how elements of the portfolio such as 'active learning' could be evidenced and suggested that a "facilitated learning needs analysis" should form part of the portfolio. MDDUS queried how assurance from the regulator would be balanced against any personal responsibility placed on individuals.

Our response:

It is helpful to receive responses that signalled broad agreement of what a CPD model based on a portfolio might look like, and this provides foundation for further work.

The feedback received about mandatory topics may not fit well with such a model, though it would not be incompatible. With such diverse roles in the dental team, identifying topics that apply to all would be challenging and may run against the ethos of giving professionals responsibility and ownership of their development.

As identified under Question 2, the feedback received supports the need to consider how appraisal systems could better support individuals and what the regulator's role would be in this area.

The decline in undertaking peer review activity was unexpected and it was certainly not the GDC's intention to direct professionals away from this with the removal of the requirement to undertake a set number of non-verifiable hours.

The COVID-19 pandemic has shown that there is a greater comfort and ability for many to communicate with colleagues and peers remotely. This may help address some of the barriers to peer review.

We will also consider how we would be assured that reflection and activities such as peer review are undertaken. It is important that they are as meaningful as possible for the individual, without the value being diminished by a worry of potential scrutiny by the GDC or others.

Q4. **How might professionals be motivated to adopt a portfolio approach now, without changes to the Enhanced CPD scheme requirements?**

Individuals

Of the 75 individuals who responded to this question, approximately half focussed their response on how to make a portfolio model practical, with suggestions around guidance and examples, including an online portfolio system hosted by the GDC, in which professionals could retain their evidence and documentation. Many respondents stressed the importance of any approach being simple and easy to follow. Approximately one fifth of respondents said that an incentive of some sort should be considered. Suggested incentives included a reduction in the annual retention fee (ARF), payment or protected time for the activity, and free CPD. A slightly less frequent theme in the responses was the need for cultural change and for widespread communications to professionals to highlight the benefits of a portfolio model, and how any new approach would work. A small number of individuals told us that they believed a portfolio model would need to be mandated for many professionals to take it up. Other feedback related to the importance of support from employers for the portfolio approach to be successfully adopted.

About one fifth of respondents expressed concern over the potential introduction of a portfolio model. Some reiterated the barriers that the GDC had set out in the discussion document, such as not having protected time off and the cost of CPD activities. Several responded that DCPs could find it difficult to adopt a portfolio approach in their current employment because they did not receive protected time to develop a portfolio or the support to do it.

There were calls for clearer evidence of the benefits of a portfolio model.

Organisations

All but one organisation made suggestions about how professionals might be motivated to adopt a portfolio approach. The OTA did not support the portfolio model and stated that any form of forward planning for CPD should not be a requirement of a future CPD model.

Some stakeholders argued that a cultural shift was needed to change attitudes amongst professionals for a portfolio approach to be adopted. COPDEND stated that the benefits of learning and sharing amongst colleagues needed promotion. SHP acknowledged that although some professionals were already planning their CPD, many expected or preferred to be told what they needed to do rather than planning their own development. MDDUS responded that the cultural change, which they said was required, should include a focus on helping professionals to appropriately tailor their CPD to their field of practice.

Both the DTA and RD suggested that there could be a greater take up of the portfolio model if its benefits were linked to developing a career pathway and new career opportunities. The DTA raised concerns about the associated costs and time as barriers to success. The RCPSG said the use of 'financial' penalties and a deadline could help to motivate professionals. The BDA responded that experienced professionals could be motivated to use the portfolio model if they could see its value but pointed out that newly graduated registrants, including those in foundation training, were already using the portfolio model which could make embedding its ongoing use easier. The BDA also referenced their own role in helping dentists to transition to a portfolio model or a PDP.

HEE, the ADG, and UCLE suggested that having a system which is easy to use, based online and reduces the burden of paperwork for professionals, would encourage professionals to adopt a portfolio model. While some of these groups suggested that the GDC should take the lead in this area, NES were explicit in stating that the GDC should not host online platforms. The benefits of having a central repository for the collation of evidence and documentation was also pointed out by the SBDN/DPA and the BDA. UCLE raised the issue of duplication, noting that some models already existed, for example an online platform SARD used within the NHS. They suggested that it would be sensible to ensure it was easy to transfer information from one system to another.

Our response:

We heard again that a cultural shift is needed to realise a portfolio-focussed model in dentistry, and we recognise that this will take time to achieve. The importance of explaining the benefits of a portfolio model, or any other model, would form part of such a shift and should not be underestimated.

Additionally, the barriers of cost, access, and time in undertaking the right CPD have been clearly heard, and the success of a future CPD model will greatly depend on how well it addresses these significant challenges.

While we recognise that a positive impact on cost would be attractive to many, this would be difficult to achieve as a direct benefit. However, there may be indirect financial benefits to professionals such as recognition of some activities such as peer review that have no cost attached, other than time, or by taking greater control of career pathways.

Until the current rules in which the CPD scheme must operate are reviewed, there is limited opportunity to mandate a portfolio model, however, we will explore how it can be trialled or encouraged before seeking a change in the rules.

Q5. Who has a role to play in making this happen? What are the roles of the professions and employers in the case of dental care professionals (DCPs)?

Individuals

A total of 73 individuals responded to this question. Approximately one third of them named organisations that could play a role, and a similar number named the GDC as having a role to play in motivating professionals to take up a portfolio model.

The organisations most frequently identified as having a role to play in decreasing order were deaneries, followed by professional associations, the NHS, other regulators, Royal Colleges, HEE and its equivalents, and indemnifiers.

More than one third of respondents addressed the role of employers directly, and most expressed a view that employers had a role to play in supporting DCPs. Several respondents argued that employers should provide DCPs with protected time, with others proposing that employers should provide additional support. Several respondents said that employers could provide more team learning activities to help employees gain benefits from peer learning, and to encourage participation and engagement across the whole team. A small number of people responded that employers did not have a role, and that it was the responsibility of individual registrants.

Organisations

Most organisations acknowledged that they, and other organisations, had a role to play. Specific references to other bodies included deaneries, employers, CPD providers, indemnity providers, education commissioners and professional associations. The GDC was referenced by the ADG and SHP as the organisation with the most appropriate remit and a corresponding duty to provide the guidance in this area.

Various organisations made comments about the role of employers. The HEE response suggested that employers could make compliance with CPD requirements part of employment contracts and that it could become part of the new NHS contract. COPDEND suggested commissioners could introduce an appraisal as a requirement for contract holders/NHS performers. SHP indicated that in-house training for all dental team members was beneficial, and COPDEND highlighted that DCPs needed more support and encouragement to make better use of their skills. The ADG suggested that employers could be encouraged to motivate DCPs by providing examples of good practice and ensuring access to online materials in the workplace. The SBDN/DPA and the OTA were of the view that employers should support team members to carry out CPD, with the OTA stressing the importance of peer interaction, particularly for lone workers. The BDA and MDDUS recognised that employers had a role to play but maintained that it was ultimately the individual's responsibility. The BDA warned that conflicts could arise between employer/owner and employee, in terms of planning their learning needs and priorities.

Some organisations made other suggestions. The DTA said that case studies for how DCPs might fulfil the requirements of a portfolio would be helpful. NES wanted to see a national appraisal system established, adapting the model already in place for vocational/foundation training. The RCPSG raised concerns about the additional pressure on professionals' time in completing CPD reflection and suggested a use of a simple flow chart or a tick-box form and noted that employers would struggle to give employees protected time off for completing forms.

Our response:

We recognise that without a change to the CPD rules, the GDC's role would be to communicate the benefits of a portfolio model, provide guidance on how to adopt such a model, and to encourage and enable dental professionals and others to put systems in place.

In order to achieve a culture shift, others in the sector would have to play a role. The GDC could encourage and support others through existing products, such as our Supporting the dental team - a guide for managers and employers.

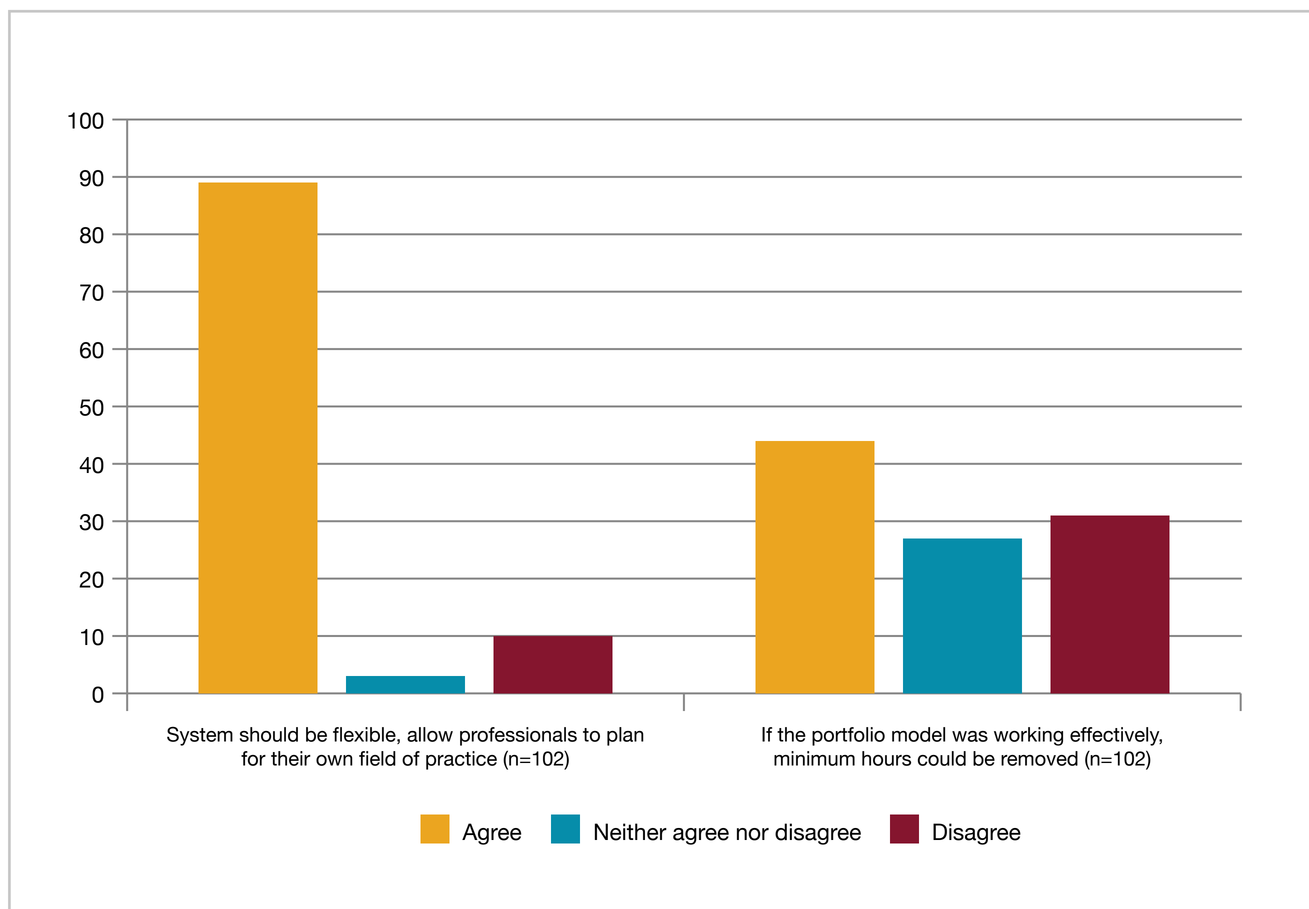
It is helpful to understand that there are mixed views on the role of employers in supporting DCP members of the team. The GDC and other organisations can facilitate and encourage, but without support from employers it may be very difficult for some dental professionals to embrace this model.

Q6. To what extent do you agree that the system should be flexible, and trust professionals to take responsibility for planning their own lifelong learning, according to their individual field of practice and needs?

Figure 3: Design of a future portfolio model

Respondents were asked to what extent they agreed or disagreed with the following statements:

- The system should be flexible and trust professionals to take responsibility for planning their own lifelong learning, according to their individual field(s) of practice and needs.
- If the portfolio model described in Question 7 (paragraph 20 of the discussion document) was working effectively, the GDC could remove the minimum CPD hours requirement for dental professionals.



Individuals

Figure 3 demonstrates a clear consensus that the CPD system should be flexible and individual professionals should be trusted to plan their learning. However, for the second statement, there was a relatively equal split of responses that agreed, disagreed, and were neutral or did not express an opinion about a potential removal of a minimum hours requirement.

Organisations

Almost all organisations agreed that a system should be flexible and allow professionals to plan for their own field of practice.

Several organisations wrote to us to provide additional comments. The BDA said that given the longstanding requirement to count hours, a significant culture change would be required if this was to be removed. They reflected that the 'culture change' needed to start in dental schools and foundation years, with further support throughout dental careers. MDDUS commented that any scheme needed to "allow for complete autonomy and responsibility for risk". NES agreed in principle but suggested a robust monitoring system, with a clear structure, was needed. In addition, they predicted that some professionals would embrace this approach, but others would need significantly more support and guidance. While the ADG also agreed, they added that there should be standardisation across fields and types of practice and stressed that professionals needed guidance for identifying the key areas to focus on.

Regarding the second question, the opinion among organisations who responded was split: five agreed that the hours could be removed and five disagreed. Two neither agreed nor disagreed.

The BDA, the DTA and NES commented further on this issue. The BDA and NES stressed the importance of sufficient guidance and support to ensure a successful cultural change, and NES emphasised the need for monitoring by the GDC. The DTA noted that the balance of qualitative (PDP) and quantitative (hours) elements to the current scheme provided technicians with clarity on how to achieve compliance.

Q7. How might professionals be motivated to take personal responsibility for their own lifelong learning?

Individuals

78 individuals provided a wide range of responses to this question. Approximately one quarter of respondents commented on a strong link between the question and being a professional, including: that it was the individual's professional duty to maintain their own learning; that this was already happening; and/or that professionals should be trusted to "get on with it". An equal number acknowledged that while some professionals would already be doing this, ultimately, any change would need to be mandated for all professionals, as many would do the 'bare minimum'. This included suggestions for more regular 'checking' and/or increased scrutiny from the GDC. Several professionals acknowledged that this would be difficult to achieve, and cultural changes would be needed. The importance of embedding this approach at the undergraduate level by educators was highlighted by some, with other comments indicating that this was already happening.

Another common theme was opportunities for career progression for DCPs to help people feel valued and gain recognition from their employers. More generally, employment support and adjustments for time out from clinic, as well as financial incentives were commonly mentioned. Several respondents suggested that discussions of CPD and CPD portfolios could be introduced into annual appraisals. There were additional practical suggestions given, such as providing case studies, and incorporating activities already undertaken into the model, such as audits, practice meetings and patient-based discussions.

Organisations

Organisations provided a wide range of responses to this question, although there were areas of commonality in their suggestions and feedback. SHP reiterated the need for a "culture shift" away from what could be described as a tick-box exercise, towards an increased understanding of the value of lifelong learning. The DTA suggested that DCPs would take on more personal responsibility for learning if this was centred on additional responsibilities and development of new skills. COPDEND and the BDA argued that registrants needed to be 'sold' on the benefits and advantages of introducing a new system, and that such benefits included greater job satisfaction, more rewarding outcomes and much more satisfied patients. The OTA said that higher quality and more affordable CPD would motivate registrants and reduce the need for compulsion. MDDUS also indicated that affordability was a factor.

HEE highlighted the push for peer support activities, arising from the NHS Long Term Plan, to improve information sharing and best practice. This, in turn, would help motivate professionals to seek training opportunities throughout their careers. The ADG also mentioned the importance of some form of peer learning activity to enable discussions on best practice, alongside a suggestion to accredit learning activities.

The SBDN/DPA made a general comment about giving dental professionals greater ownership and responsibility for CPD, but also raised an issue of the value of real-time learning. The SBDN/DPA, NES and the RCPSG all stated that this needed to be embedded in undergraduate and primary training for future professionals and reinforced after qualification. The SBDN/DPA, MDDUS and NES also mentioned the role of employers in encouraging CPD activity during working hours, with NES acknowledging that there would be funding implications.

The BDA raised concerns about how such a scheme would be 'policed', particularly for those taking time out from work. They also suggested that given that the existing scheme was relatively new, that time should be given to allow it to embed, and its impact and effectiveness assessed before any changes were made.

Our response:

We heard in the feedback that the responsibility for the learning undertaken sits with the individual professional. There were a range of views on the need for GDC oversight to allowing individuals to self-regulate their activities.

A prediction that some will tend towards doing as little as they can to get away with appeared to be a concern for a sizeable number of respondents. This is something that we will be conscious of as the proposals and auditing and assurance mechanisms are developed. It isn't just the threat of being checked that we need to focus on, but also on the explanation of the system and the support put in place to help people comply with and get the most from the scheme.

Q8. Thinking longer term, if the portfolio model described was working effectively, do you agree that the GDC could remove the minimum CPD hour requirements for dental professionals?
Q9. What are the advantages and disadvantages of removing set CPD hour requirements?

Individuals

Of the 84 people who provided a response to this question, the majority identified that there may be both advantages and disadvantages in removing set CPD hour requirements.

The most frequent advantage identified was that removing these requirements would make CPD less of a 'tick-box exercise' driven by a need to comply with regulatory requirements. It would encourage professionals to seek out more meaningful and better quality CPD, better tailored to individual needs and field of practice.

A small number of respondents cited the possible advantages of an increase in trust in professionals and a reduction in the financial burden for DCPs.

Regarding disadvantages, half of all respondents said the amount of CPD done would go down as a result of removing a minimum hours requirement, arguing that some professionals would do very little or no CPD as a result.

There were also concerns about how compliance would be verified. Some individuals told us that they were not clear about how meeting the requirements of a system without a minimum hours requirement would be checked. Others posed questions about the clarity and amount of guidance, and whether there would be a measurement system in place.

Interestingly, the recommended topics came up frequently in the response to this question were often referred to as 'core', 'compulsory', or 'mandatory'. Their removal was seen by many as undesirable, with some respondents commenting that if the topics were removed, some topical CPD would no longer be completed. However, others cited their removal as an advantage, in that it would enable professionals to better tailor learning to their individual needs.

A minority of respondents did not provide specific advantages or disadvantages but responded that in principle they strongly disagreed with removing the minimum hours requirement. They said the current minimum hours were not difficult to achieve, were easy to measure, and maintained consistency.

Organisations

Approximately half of the organisations outlined some advantages and/or disadvantages, while others made general comments about removing the minimum hours requirement. Of those providing general comments, RD, the DTA, the RCPSG and UCLE stated that they were not in favour of their removal. RD argued that the requirement kept the system transparent and fair while the DTA highlighted that a minimum hours requirement is easily measurable and works well in combination with keeping a portfolio. UCLE acknowledged that although time spent did not necessarily equate to improved knowledge and skills, a minimum requirement was still helpful when it was combined with reflection.

SHP stated that even without the minimum hours requirement they considered some form of verification of CPD must be carried out. COPDEND emphasised the need for cultural change before the minimum hours requirement was removed, suggesting that without it the scheme could become "open to abuse". HEE highlighted the necessity of robust testing before such a model could be implemented, with careful consideration needed to be given to the potential impact on personal development and career pathways. The SBDN/DPA commented that while they thought that some CPD was currently undertaken to meet the minimum hours requirement, without necessarily improving skills, the requirement nonetheless acted as a guide for how much time should be dedicated to CPD.

With reference to advantages, both HEE and MDDUS suggested that a scheme with no time requirements would mean CPD could be better tailored to roles and field of practice. MDDUS stated that the removal of the minimum hours requirement would also encourage self-directed learning. The BDA supported the move away from counting hours but called for the removal to be supplemented by a "clear guidance on what is required instead" and urged the GDC to work closely with professional

bodies to support the transition away from the minimum hours in what they described as a 'culture change'. The ADG responded that this would reduce the administrative burden and the pressure to 'hit' a certain number of hours, while allowing professionals to make better use of peer interaction and peer learning that was already taking place.

HEE, like many individual respondents, noted that some individuals may not carry out sufficient CPD without the hours requirement, while MDDUS suggested that professionals might reduce the variety of CPD undertaken. The OTA reflected that the current requirement acted as an encouragement for those who needed a set minimum to motivate them, and that without it some professionals might not complete as much CPD as they currently do. They also suggested that removing the minimum hours may affect employers' attitudes to giving time off work for CPD. The BDA suggested that a removal of the minimum requirement may be initially confusing, and that dental professionals could fail to comply with CPD rules without realising it. They stressed the importance of a wide-ranging outreach programme prior to any planning for a new system. The ADG responded that the minimum requirement made auditing and evidencing easy, and that without it, it would be difficult to quantify professionals' efforts.

Our response:

Respondents were split on the idea of removing the minimum CPD hours requirements, even with a working portfolio model in place. Recommended topics are seen by many as mandatory, which they are currently not.

If the hours requirement is removed in a future scheme, we would need a way to check compliance, and this will clearly not be as simple as counting hours. Although this may be challenging to develop, we don't think that this difficulty should be the single determining factor of whether a scheme should be adopted.

It can be argued that any scheme can be open to abuse or gaming. Even within the current scheme where hours are counted, the time spent participating at an event or reading an online document and answering questions may not equate to the time on the certificate. Giving greater trust to professionals may be part of the culture change that the respondents had identified was required to make a different system work.

There are barriers, and time is a significant one. Some may be willing to seek development in their personal time, but this will not work for everyone, and much will depend on an employer's attitude to their staff development. The GDC can seek to influence, through mechanisms such as our Supporting the dental team - a guide for managers and employers, but we do not have authority to mandate employers to give staff time off for learning and development.

A new system will require careful thought, development, impact assessment, testing and communication before it can be introduced, and after introduction further work will be required to embed it into practice, including by providing clear guidance. While the GDC may lead on some of this, we will require the help and support of other organisations and individuals.

Q10. How might assurance be gained, and provided, to demonstrate to the GDC that professionals are undertaking their lifelong learning effectively?

Individuals

81 individuals responded to this question with a range of suggestions as to how assurance of effective lifelong learning might be achieved. Randomised audits or 'spot checks' were commonly mentioned, as was a declaration or statement, like the one in place under the current eCPD rules. Linking assurance to the maintenance of a portfolio was a popular response, either in isolation or alongside audits and, less commonly, in combination with appraisals or peer review. Others suggested maintaining forms of evidence, for example, certificates. Others went further and suggested an online system in which evidence could be submitted directly to the GDC.

Some respondents commented that assurance could not be gained effectively as it would be vastly expensive and impossible to achieve. Others said that the current system of assurance was effective and should be retained, while a few individuals responded that no assurance was needed because professionals could and should be trusted to complete CPD.

A small number of respondents talked about a potential role for employers in gaining assurance of effective lifelong learning. Some also commented that the answer depended on what the GDC was trying to achieve and which methods it considered effective.

Organisations

Some organisations made similar suggestions to those from individuals. The RCPSG, the BDA and RD suggested that a self-declaration, which forms part of the current system, could be used for assurance purposes. The ADG, the RCPSG and the OTA suggested sampling random selection of records to check compliance, with the RCPSG adding that this would remind professionals of the requirements and keep them on track. The BDA also said that sampling a small group of dental professionals for an audit, which is part of the current system, would be suitable but they would not support a system of routine disclosure of all record to the GDC.

SHP suggested some form of annual monitoring, such as submission of PDPs, whilst the ADG said that the portfolio itself would provide sufficient evidence of effective lifelong learning. SHP also suggested that external agencies could play a role in carrying out assurance of compliance. The DTA suggested that accreditation of CPD providers could offer the assurance sought. The SBDN/DPA queried what the GDC meant by 'effectively' in practice , and how effectiveness of lifelong learning could be measured, adding that a framework of GDC expectations could provide a vehicle for developing a system of assurances.

HEE suggested that peer learning groups, working locally, could provide assurance and take responsibility for members' needs. Of a similar view were MDDUS, who suggested that such assurance could be provided by a mentor or a representative of a deanery. The BDA was not supportive of engagement of assessors or similar, raising issues such as additional costs that might be involved in this and any "legal responsibilities this placed on assessors and increased paperwork for the registrants".

UCLE suggested that the GDC website [eGDC] could be used better to help determine whether dental professionals kept up-to-date with their CPD. The RCPSG suggested the development of an app, linked to the GDC's system, which would facilitate the transfer of records.

COPDEND noted the need for cultural change and the importance of embedding an understanding amongst professionals that certain activities such as peer review and reflection were 'normal' CPD activities.

Our response:

At present, we have a binary check for assurance: you have either done enough hours or you haven't. This may not be replicable in the scheme proposed, but this doesn't mean that compliance cannot be checked.

We will need to balance the level of assurance against the costs and burden on professionals, the regulator and the wider healthcare system that would be required.

The comments and suggestions we received in response to this question are very helpful, but we recognise that we cannot develop the assurance scheme until a future scheme is in clearer focus.

Part 2: CPD practices

Q11. **Which active learning activities do you feel would be most beneficial and why?**

Individuals

83 people responded to this question. Around a third identified the most beneficial active learning activity as group work, with courses and online webinars following closely behind. Other activities cited were, in decreasing numbers, attending events, observing others during clinical activities, reading journals and articles and “mentoring”.

In terms of specific suggestions, a number of respondents raised the importance of hands-on learning and referenced the positive role that “phantom heads” can play in learning and improving techniques. There was a specific reference to master classes provided by the DTA. Several respondents also cited benefits of ‘in-house’ and ‘whole team’ learning, as it was viewed as a shared venture across the dental team.

Several respondents argued against relying solely on online provision of learning, while others noted the importance of ensuring that any learning was suitably tested, as attending alone was considered insufficient when assessing whether competence had been improved.

Q11 (continued). **Which are the most practical learning activities?**

Individuals

77 individuals provided comments on this topic. Most respondents said that active learning, courses and webinars, and group work were the most practical activities. Mentoring, peer review, and courses were also cited, albeit to a lesser degree. In terms of specific proposals, responded mentioned case studies, reviews, and peer discussions as examples of practical learning options.

One respondent highlighted the importance of not creating ‘one size fits all’ solutions, while another noted that different dental professionals or groups of professionals had varying levels of experience and would need activities that met their specific needs. Some also raised the need to have opportunities for weekend and evening learning.

Organisations (responding to Q11 and Q11 (continued))

Organisational responses varied on the benefits and practicalities of active learning. Some suggested specific kinds of activities, whilst others expressed caution about the concept of active learning.

The DTA stated that role-play and small peer group work was beneficial. They said that problem-solving and scenarios could be more practical if hands-on learning was not available. The ADG suggested that peer learning, along with workshops and shadowing, was beneficial in gaining first-hand experience and support while interacting with colleagues. COPDEND referenced hands-on activities more generally, as well as group-work for teams, but noted that the availability of cheap materials was key to the effectiveness of such activities. The OTA also mentioned hands-on activities and said they were beneficial for “trying out” new materials and techniques and, importantly, for providing an opportunity to interact with peers. Courses provided directly at the workplace (for example by manufacturers and traders) were considered practical, while others said that courses which brought individuals out of the workplace were better as they enabled interaction with peers and other members of the dental team.

SHP also mentioned practice-based activities, where teams learned together; peer review, coaching and mentoring, and sharing and discussing case studies. NES also suggested that peer learning, simulation, case discussions, and direct observation would be beneficial, particularly when combined with assessment tools. UCLE suggested that the types of activities would depend on the work undertaken by the individual dental professional, and any associated costs.

The SBDN/DPA noted the need to be cautious about suitability of active learning to the full range of dental professionals on the registers, especially those in non-clinical roles, and the need to be non-prescriptive. They suggested that to be practical, activities needed to be 'learner-centric', incorporating problem-solving and focus groups, and needed to be a good fit for the individual's learning style. They also raised concerns about cost and availability becoming barriers to accessing this type of learning for some DCPs.

The RCPSG also raised issues of cost and time associated with active learning. They also commented that hands-on courses were more useful and effective compared to theory alone. MDDUS said that professionals should have their learning style formally assessed. They acknowledged the benefits of hands-on learning and workshops but cautioned that supply may be an issue across the UK. HEE suggested that active learning had a place, particularly for clinical skills, but that it should be part of a broad-based blended model.

The BDA did not agree that active learning needed to be more formally encouraged or that it needed to be prioritised above other activities and warned that any such prioritisation could be too prescriptive.

Our response:

We note that overall, most respondents considered active learning carried out in workplace with the whole team or with peers to be a useful part of CPD activities and note the breadth of activities on offer including some online activities.

We assume that during the COVID-19 pandemic many face-to-face activities mentioned by the respondents moved online or to another form of distance learning. As we move forward with our thinking we will be keen to explore the impact of any such shift on both the take-up of these types of active learning and any impact on their effectiveness.

We take on board the caution about active learning or some types of active learning being more suitable to some professionals and learner types more than others. We will consider how in any future system we could combine flexibility with ensuring that this type of CPD is accessible to all.

We note the caution sounded by several respondents about over-reliance on online or distance learning. As we develop our thinking, we will explore how the views shared regarding the benefits or otherwise of online and other forms of distance learning may have changed through the pandemic.

Q12. **How can common barriers to accessing the most beneficial activities, such as geographical isolation and limited options for DCP groups, be overcome? Who can or should reduce these barriers?**

Individuals

76 individuals responded to this question. Many said that online provision helped to address geographical isolation, while others suggested there should be more courses provided locally in 'skills labs'. Several respondents proposed securing more support from system partners, such as universities, deaneries, local clinical networks, and professional bodies. A few respondents also cited the GDC as having some responsibility for improving access.

Most respondents said their proposals applied to all categories of dental professionals, although a small number identified a specific need for training to be made available locally for dental nurses and suggested that it should be provided by employers.

Organisations

Organisations frequently raised the issue of costs as a barrier and said that the provision of online materials could help reduce them. However, many stressed that online provision should not replace all face-to-face learning. A few organisations addressed the question of whose role it would be to help reduce barriers. HEE was mentioned by the DTA and UCLE, while MDDUS said the responsibility lay with the deaneries and the Department of Health and Social Care. HEE, however, suggested that training providers and professional bodies could help to reduce barriers. The SBDN/DPA told us that employers had a role in the provision of lifelong learning for teams. The BDA commented that professional associations had an important role to play.

Some organisations focussed on training providers. COPDEND, for example, suggested the use of 'mobile skills labs' to help cut costs and solve access issues. The ADG said that providers could host activities across more locations and outside of typical working hours. The OTA noted that the quality of training was paramount in ensuring that those attending could gain maximum benefit.

The BDA noted the need to avoid inflexibility, suggesting it could lead to recruitment issues, and the RCPSG highlighted that poor advertising could limit access to courses and suggested the use of a centralised website to raise awareness of CPD courses.

Our response:

Like many respondents, we agree that active learning shares some barriers and disincentives with other forms of CPD. These include costs, lack of course availability and gaining protected time to undertake the activity.

It is interesting that many respondents called upon education providers, commissioners and NHS leaders to take the lead in developing and supporting the local active learning offer and offer more online learning. We were also interested to see the suggestion that professional bodies should use their local networks and online offer to do so too.

We will work more actively with these stakeholders to explore how they can support their members and employers to engage in active learning.

Q13. **How might the professions be supported or encouraged to seek out active learning activities?**

Individuals

63 individuals responded to this question. The largest number of respondents recommended tackling the cost of learning by providing direct financial support, providing courses free of charge, or by providing protected time off to undertake learning.

Other recommendations focussed on improving how learning opportunities were promoted and publicised, with suggestions for some form of centralised notice board and/or central database to be created with information about available courses and their cost.

Organisations

Organisations responded with a mix of suggestions for motivating professionals and for which parties might play a role.

SHP suggested various educational bodies that could play a role and creating a website to advertise all available courses from recognised providers. HEE suggested professionals could be encouraged to seek out learning activities through peer learning support networks. UCLE commented that the GDC should encourage professionals to seek out learning activities and suggested that a new website could host activities and providers. The BDA also suggested guidance from the GDC, professional associations and other stakeholders.

In relation to DCPs specifically, the DTA said it was important that opportunities for DCPs to develop their careers were available. The SBDN/DPA commented that practice-based team learning was a good approach to ensuring engagement from DCPs.

The RCPSG and the ADG both told us that the benefits of active learning need to be promoted to encourage professionals to seek this out. The ADG reflected that activities should fit around modern work patterns to encourage professionals to undertake them. COPDEND said opportunities could be promoted through articles in journals and discussions with colleagues. The OTA stated that if active learning opportunities were interesting, relevant, and affordable then barriers would be overcome, and re-emphasised the value of online learning. MDDUS suggested that better availability and affordability of active learning would encourage professionals to take up more activities.

Our response:

Like many respondents, we agree that professionals want to engage in lifelong learning as part of being a professional, but we were keen to hear what, if anything, the GDC could do to support a greater take up of active learning. We heard several suggestions that the GDC could act as a notice board of CPD activities. We can see a lot of benefits in having a single source of information on CPD courses. Becoming a host for it might sit uneasily with our role, but we can certainly discuss with stakeholders how courses can be better promoted.

We will also take on board other suggestions such as the importance of encouraging professionals to see the benefits of these activities to their career and skills development. We already talk to employers of dental professionals about the importance of CPD to their employees, but we will explore how a future system could make more of the links between CPD and career progressions and professional growth.

Q14. What types of peer learning would be beneficial and why?

Individuals

72 individuals provided comments to this question. Group discussions and group-based learning was referenced by some, while others suggested case-based discussions. A smaller number of people mentioned mentoring, peer audits and shadowing. Some respondents referenced study clubs as a mechanism for bringing dental professionals together to learn.

Most respondents cited the benefits gained from sharing information and experiences as key reasons for recommending these approaches.

Organisations

Almost all organisations responding to this question agreed that the various types of peer learning suggested in the discussion document were beneficial, including:

- case discussions
- clinical incident analysis
- peer review
- mentoring and coaching
- shadowing and
- peer audit.

NES emphasised that the benefits of the activity were dependent on the topic, and the RCPSG noted that peer learning with colleagues at the same professional level could be particularly beneficial. The SBDN/DPA suggested that mentoring did not fit within discussions around peer learning, as it had a much broader remit. SHP suggested that portfolio discussions, as part of a peer review network, would be beneficial.

Some organisations also suggested that encouraging peer learning for the purposes of CPD would bring structure to existing informal arrangements, build skills in problem solving and coping with ambiguities, and encourage learning directly first-hand from their colleagues. The OTA and COPDEND noted that watching colleagues or other professionals work was a good learning opportunity. The BDA said that peer review was a popular way for dentists to discuss issues that were important to them and of identifying best practice. The BDA agreed that coaching and mentoring was “beneficial” but noted that it is most frequently used “when something has gone wrong”.

Some organisations raised issues with peer learning. For example, the SBDN/DPA suggested that for peer learning to be successful there needed to be mutual trust, and perhaps even a buddy scheme in place, to create safe learning spaces. UCLE noted that most professionals worked in a dental practice with a small number of peers and that this would limit peer learning opportunities. UCLE also noted that the GDC had a role to play in the development of a peer group network.

Our response:

We were very encouraged to see a breadth of peer learning activities supported by respondents, from study groups to case study events that are already taking place. A future system should recognise these valuable activities as CPD. It is possible that this could help formalise existing arrangements as well as improve the type and range of activities on offer.

It was also enlightening to hear about the range of benefits such activities bring, from learning new clinical skills and providing safe spaces to discuss concerns, to reducing isolation and burnout. This vastly improved our understanding of what might constitute peer learning for many professionals and of the value they could derive from it. We are keen to ensure that these benefits are captured by the future system.

Q15. What types of peer learning are practical?

Individuals

60 individuals responded to this question. Quite a few respondents echoed previous comments on what types of peer learning activities would be beneficial, referencing:

- group work
- online courses
- mentoring
- the use of case reviews and studies
- action learning.

There were some novel proposals, for example, a suggestion that staff in primary care dentistry could visit other practices to observe dental professionals. Other points raised included the need for any provision to be affordable and provided at suitable times of the day, fitting around the professionals' work commitments.

Organisations

The DTA suggested scenario-based learning and problem-solving practical activities. COPDEND, MDDUS and UCLE suggested local study and discussion groups, with UCLE noting that these could be delivered remotely. The RCPSG suggested that supervision of cases could be valuable, possibly alongside colleagues and in study clubs. The SBDN/DPA submission mentioned local in-practice activities, such as morning huddles or team debriefs. The OTA discussed how laboratories and practices could interact more, by inviting each other to visit their premises and sharing learning. NES commented that all types of peer learning could be undertaken with appropriate support and funding.

The ADG also suggested case discussions, as well as mentoring and coaching, but were wary about the availability of such activities. The BDA suggested that mentoring and coaching, in the way they are currently practised by members, were better suited to addressing specific issues, for example, following a fitness to practise case or a patient complaint. They pointed to the General Pharmaceutical Council's peer review scheme as an effective example.

Here and elsewhere in their response, the BDA called on the GDC to set out more clearly what we meant by 'coaching' and 'mentoring'. They commented that in their view there was no shared understanding among the professionals of what they meant.

Our response:
We note, as mentioned above, from these responses that many dental professionals already either participate or aspire to do a range of peer learning activities that are not 'verifiable' for the purposes of eCPD yet are clearly a valuable part of many dental professionals' ongoing learning. It is clear that a future scheme must account for any activities already taking place and make taking them up accessible and attractive.

We take on board the importance of developing a shared understanding of what constitutes 'coaching', 'mentoring' and other types of CPD that could form part of a future system.

Several respondents noted that online and remote learning opportunities were more practical. The discussion document was published before the pandemic which saw a proliferation of online and other distance learning courses. We are keen to explore if this trend continues after the pandemic, and what impact it has had on CPD, including on increasing access, reducing costs and developing new forms of interaction and learning.

Q16. What are the barriers to peer learning, for which groups, and how should they be overcome?

Individuals

Of the 102 respondents, 70 responded with suggestions. Time, cost and geographical availability were the most commonly cited barriers to be overcome.

Others pointed to individual capabilities, such as some dental professionals not feeling confident enough to access peer learning, or not having sufficient information or experience to be able to choose the most suitable courses. Two respondents noted poor availability of mentors as a barrier.

Respondents offered a range of means by which to overcome these barriers, referencing previous responses, such as:
- online provision
- having protected time off
- working in groups and with coaches.

Respondents referenced all professional categories and did not identify any barriers for specific professional groups

Organisations

Organisations such as SHP, HEE, COPDEND and SBDN/DPA commented that some professionals were fearful or concerned about being transparent with colleagues and stressed the importance of creating the right working environment to help professionals overcome this fear. The DTA, on the other hand, noted that some could view their peers as competitors, which could result in an unwillingness to speak freely. The SBDN/DPA said teamwork should be embedded in undergraduate education programmes, to improve professionals' people management and leadership skills.

The OTA, BDA, MDDUS, RCPSG and NES suggested that time, funding, and location were all barriers to the adoption of peer learning. Suggestions for how these could be overcome included:

- online options
- running activities with small registrant groups at practice level
- protected time off for these activities.

The BDA also suggested that one of the main barriers to peer learning was the lack of schemes available and noted that [if such schemes were to be developed] professionals would need to be trained to facilitate them. In a similar vein, the ADG noted that the success of peer learning events was dependent on effective facilitation. They suggested that professionals could be trained to provide effective facilitation.

Our response:

We are hearing that effective peer learning relies on having trained peer facilitators and that the current lack of such schemes could be overcome with more support for aspiring peer facilitators to gain such skills.

Whilst the current scheme recognises any verifiable CPD to improve one's learning style or gain skills in facilitation and chairing, a future scheme should also recognise peer learning CPD activities which could support more dental professionals into gaining peer facilitation skills.

We are aware that for many, being required to undertake CPD in their personal time is a barrier to greater take up of peer learning and many other types of CPD. Whilst we cannot mandate employers how to support lifelong learning of dental professionals, we can encourage them through guidance and support, raising awareness of benefits of CPD to patient care and satisfaction, and to improving skills of their workforce.

Q17. Outside of the GDC, who has a role to play in supporting peer learning?

Individuals

66 individuals responded to this question. They identified a range of sources of support, with the most common being:

- Professional associations e.g. the BDA.
- Employers.
- Universities.
- Colleagues.

Other sources cited were:

- The NHS.
- Dental defence unions or indemnifiers.
- Education and training authorities e.g. HEE, NES.
- Local Dental Committees (LDCs).
- Local dental groups.
- The Government.
- Royal colleges.

A small number of respondents also suggested the GDC and the systems regulator Care Quality Commission (CQC) and national equivalents.

Organisations

Organisations named a similar range of sources of support to individual respondents. Most commonly, organisations cited professional associations and HEE (and equivalents in Wales, Scotland and Northern Ireland), alongside education providers and other education and training institutions, such as deaneries and faculties. Other bodies mentioned included:

- Employers.
- Local Dental Networks.
- LDCs.
- Indemnifiers.
- Dental hospitals.

Our response:

It is encouraging to see many respondents, including professional organisations, recognising their and other stakeholders' role in supporting peer learning.

The organisation types listed are directly involved in or have an interest in clinical and professional development of trainees, students and registered dental professionals. We will share with them these findings to help us explore together how to encourage and support dental professionals, both to take up peer learning and to become skilled facilitators.

The current system already recognises verifiable CPD in skills, such as peer facilitation and effective chairing. We will ensure that the future system recognises a broad range of such learning activities.

Q18. How might reflective practice be incorporated into the Enhanced CPD scheme?

Individuals

60 individuals responded to this question. Two themes emerged in relation to incorporating reflective practice, these were:

- providing templates and guidance to support the capturing and recording of reflective practice
- for it to be made mandatory for dental professionals.

In support of the latter point, a few respondents suggested connecting reflective practice more formally to organisational appraisal and reporting arrangements.

A few respondents said that reflective practice was already incorporated into existing practice, but that further work was needed to support this.

Organisations

The ADG, SHP, NES and MDDUS all noted that there was confusion or uncertainty among the professionals about how to 'reflect well', with some also reporting a 'fear of criticism'. The ADG told us that CPD providers could be doing more to incorporate reflective practice into existing activities. MDDUS and NES said that more education was needed about reflection, whilst SHP noted that further guidance and/or templates on reflection would be helpful. The SBDN/DPA submission noted that a framework describing or illustrating best practice in reflection would be useful. The OTA commented that a simple process would work best. COPDEND suggested benefits of reflective practice should be promoted more widely. HEE said they recognised the benefits of reflective practice and suggested that the GDC could consider making reflective practice mandatory. UCLE suggested that reflective practice could be incorporated into an appraisal scheme to assure that it was taking place.

The DTA was cautious about reflective practice, suggesting that it could turn into a 'tick box' activity, and that it might be less appropriate for some groups and activities. The BDA stated that reflection was already sufficiently incorporated into the Enhanced CPD scheme, but that the scheme could be built upon, "as long as it remains non-prescriptive and personal".

Our response:
Reflection forms part of the current eCPD scheme, and the purpose of this section was to gain insights into how it can be better embedded into the current and any future scheme. We are pleased to see that on the whole, reflective practise is seen by most respondents as beneficial, if not essential. We will take on board the comments that professionals could benefit from better support to 'reflect well' and that a lot more could be done to promote the benefits of reflection.

Q19. What are the barriers to introducing reflective practice into the Enhanced CPD scheme?

Individuals

77 individuals responded to this question. As with previous responses, time and cost were frequently cited as barriers. Several respondents also noted that some dental professionals might lack interest in, or understanding of, the concept.

Although not a sizeable number, a few respondents also cited a fear of any outputs being used, or having the potential to be used, against dental professionals either in litigation or in fitness to practise proceedings.

Organisations

Organisational responses cited similar issues including:

- lack of familiarity with the concept
- lack of understanding of its impact
- poor insight or appreciation of reflective practice
- funding and time constraints.

MDDUS also mentioned that there existed a "climate of fear" and professionals may be fearful of their reflection being used in litigation and fitness to practise proceedings. UCLE noted that current expectations around reflective practice lacked robustness for assurance purposes. The OTA noted that

individuals might be naturally resistant to something forced upon them by the regulator. The BDA stated that an evaluation of the current scheme would provide indicators of what support was needed [to improve take up of reflection].

Our response:

As above, it is clear to us that we can do more, together with others, to promote what reflection is and how it benefits practice, as well as dispel any fears about the possibility of reflection being used in litigation and fitness to practise concerns.

We note with interest many suggestions in responses to this section for improving robustness of the oversight, to ensure that reflection becomes more integral to CPD. We note the calls to evaluate how well reflection is used in the current scheme and will build this into our plans for the review of eCPD.

Q20. What structure(s), framework(s) or model(s) of reflective practice could be used for dental professionals? Does this vary across the different groups of dental professionals?

Individuals

57 individuals provided suggestions in response to this question, which garnered a wide range of responses. Many responses provided references to published research or studies into specific models that the GDC could consider adopting, including Bolton and Moon, and NHS Improvement's Plan-Do-Study-Act tool for improvement.

A few respondents also provided practical suggestions, mostly in line with responses to previous questions, for instance, about using group approaches and providing guidance and templates for dental professionals.

Organisations

The SBDN/DPA and MDDUS suggested that different professional groups could suit different form of reflective practice. The SBDN/DPA also suggested that employment settings would also affect what was considered appropriate. They mentioned several reflective tools, such as Kolb's and Gibbs' reflective cycles, and the Johns model of reflection. They added that consideration should be given to the views of Carl Rogers, who advocates a person-centred approach to reflection.

NES noted that the best approach to reflection would be dependent on the individual's learning needs, identified through appraisal. The RCPSG also referred to individual needs and learning history. The BDA said that individual approaches would need to be different and would be dependent on the role and on the work setting and noted that flexibility in this area was warranted. The BDA stressed that reflection was different from appraisals and carried a different level of influence. The BDA added that there was a need to consider the power dynamic between employer and employee.

Conversely, HEE took the view that the principles of reflective practice should be the same for all groups and suggested the use of a 'Charter Mark' to highlight exceptional service, which could be replicated for reflective practice in teams. The ADC suggested the usage of Gibbs' reflective cycle as, in their view, it was well-rounded and applicable to all dental professionals.

SHP suggested that templates [for reflection] and using open questions were helpful, and the latter was echoed by COPDEND. SHP also referred to Isopharm as a good provider of support for reflection following CPD activities.

The DTA stated that a critical review of current providers of reflective practice would be helpful. Similarly, UCLE called on the GDC to carry out an analysis across the dental sector of what was currently in use.

Our response:

In responding to what we heard in this section we will need to ensure that the scheme meets the needs of individual learners and of groups of dental professionals.

We thank respondents for the many reflective tools they suggested. The sheer variety of tools suggests that good, diverse practice in reflection exists, even if not all dental professionals at the moment are able or know how to make best use of reflection, and that awareness raising of existing tools could increase both the take up of reflection and its effective use to improve practice.

We also take on board suggestions to review how reflection is currently used as part of eCPD. It will form a key part of our plans to evaluate eCPD uses and practices, which is the next step in this project.

Some respondents suggested incorporating reflection into appraisals. Whilst we cannot mandate how employers should manage their employees, we can certainly try to better support employers to see the benefits of reflection through our Supporting the dental team - a guide for managers and employers, and through engagement with large employers and with professionals bodies.

Q21. How can dental professionals be encouraged to do more reflection?

Individuals

This question prompted a range of responses. Many respondents focused on the GDC's Enhanced CPD arrangements, for instance suggesting making reflection mandatory and reportable, or adding it to the guidance on developing PDPs for dental professionals. Some respondents suggested that the GDC should provide examples, or templates, for dental professionals to follow.

Some respondents also recommended, for those who are subject to them, including reflection as part of appraisal systems. Finally, some respondents cited the need to promote reflection more widely and to demonstrate its benefits for dental professionals.

Organisations

The OTA, COPDEND, the DTA, the ADG, NES and the SBDN/DPA submissions noted that 'selling' and educating professionals on the benefits of reflective practice would help to encourage professionals to do more reflection. The ADG also suggested that peer learning events could be used for reflection, if there was sufficient guidance for facilitators. SHP and MDDUS suggested that more could be done to dispel fears about the use of reflection in [fitness to practise] proceedings.

The BDA suggested that professional bodies had a role to play in supporting professionals and in positively influencing attitudes towards reflection.

UCLE suggested that the use of reflection could become a requirement for ongoing registration with the GDC, whilst the RCPSG suggested it should be kept voluntary and not be repetitive.

HEE took a more practical approach by suggesting the creation of learning materials such as:

- case studies
- examples of good practice
- identification of reflective practice 'champions'
- incorporation of reflection into PDPs and appraisals.

Our response:

We take on board the points made here and in response to the section above about making reflection mandatory or making more stringent checks about whether it is carried out. We are keen to make the new system more flexible and will need to assess if further embedding of reflection can be done effectively without introducing some form of compulsion or reporting.

Our initial response is that it might be possible if it is better understood and promoted and if professionals are supported with easy-to-use tools. We are pleased to see that the role of educators and employers in promoting and embedding reflection is recognised, and will continue to work with them to make reflection a more integral part of CPD.

Part 3: Informing CPD choices

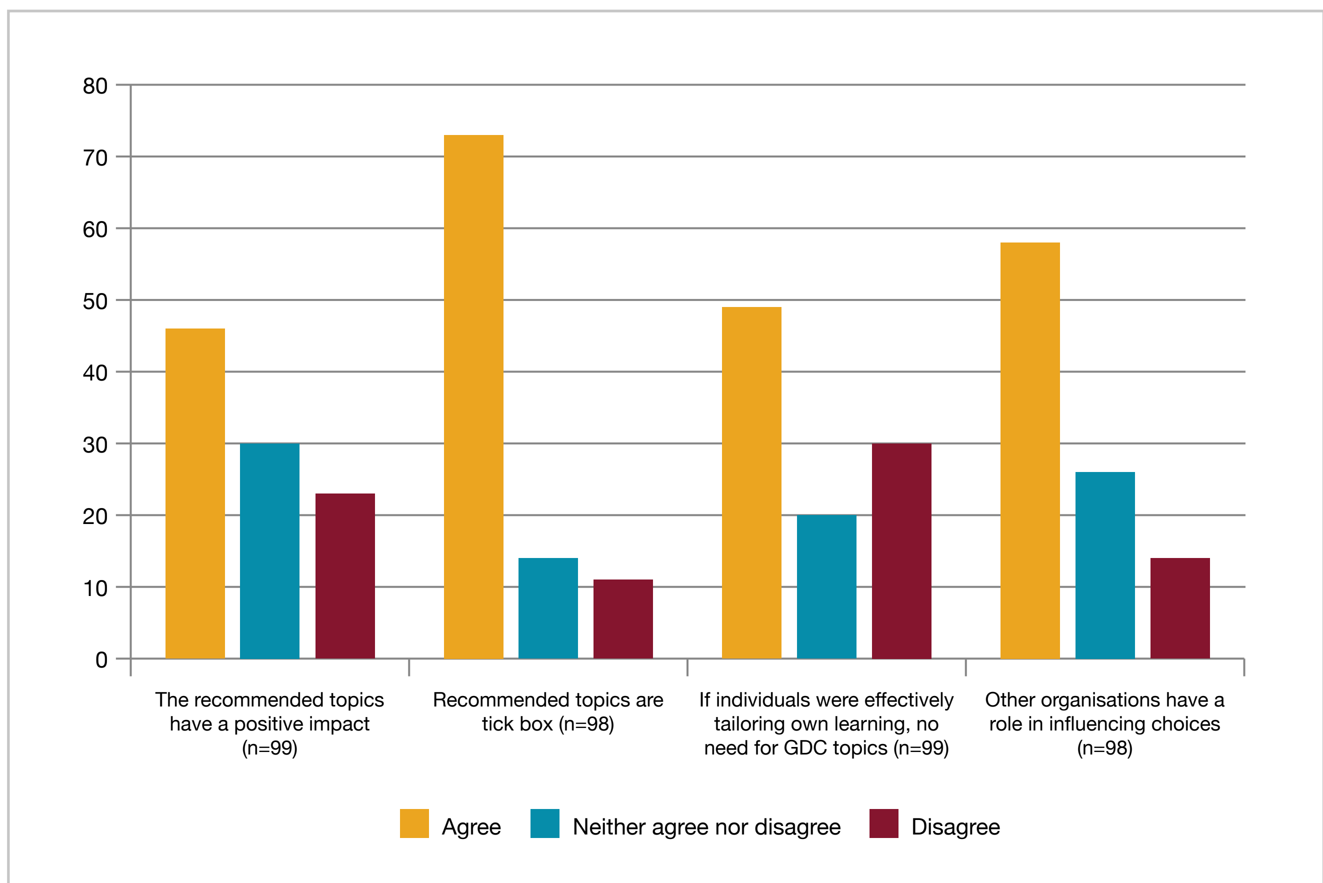
Recommended topics

Q22: **Do you think recommended topics have a positive or negative role in planning and CPD selection?**

Respondents were asked whether they agreed or disagreed with the following statements:

- The recommended topics have a positive impact on CPD planning and selection for dental professionals.
- The recommended topics are used as a 'tick box' for dental professionals selecting their CPD, rather than being considered against an individual's field(s) of practice.
- If individuals were effectively tailoring their own learning according to their individual field(s) of practice, there would be no need for GDC recommended topics.
- Other organisations and bodies have a role to play in influencing CPD choices for dental professionals.

Figure 4: Recommended topics – individual responses



As figure 4 shows, most individual respondents agreed that the recommended topics had a positive impact on CPD choices. However, a significant portion either did not express a view or disagreed with the statement. However, a large majority also agreed that completing recommended topics was a 'tick-box' exercise. Regarding the third statement, results were more mixed when compared with the

first, with most respondents agreeing that there would be no need for recommended topics if professionals were planning their learning according to their needs. Finally, a clear majority told us that other organisations had a role in influencing CPD choices for dental professionals.

Organisations

Many organisations could not definitively say if recommended topics had a positive impact. Some gave examples of where recommended topics benefitted their members, for example by ensuring that professionals practised safely and kept up to date on radiation exposure and medical emergencies, by forming a framework around which professionals could build their personal development plans (PDP)s, and by providing opportunities to learn with other members of the team to those who by nature of their work did not normally do so.

Almost all organisations, however, were of the view that recommended topics had become a ‘tick box’ exercise for dental professionals.

Q23. To what extent do you agree that moving to a portfolio model, where individuals drive their own learning, will negate the need for GDC recommended topics?

Some organisations offered a view on this topic, with several agreeing with this statement and others suggesting the topics should be retained or pointing to both positives and negatives of retaining them.

Our response:

We will reflect on the different views we received on the future of recommended topics and consider whether the benefits they bring can be realised through other means.

It is worth noting that here and elsewhere in their responses, many referred to ‘recommended’ topics as mandatory. The topics are not mandatory, but it is possible that communications from the GDC and the way our guidance is interpreted by others suggests otherwise.

We are determined to make a future system work for all groups of dental professionals operating in all settings, and it is clear that the current system, including recommended topics, may work better for certain groups of professionals, such as those with regular direct patient contact, than for others.

Q24. **How can CPD choices be better informed?**

Individuals

Of the 102 individual respondents, 52 made a comment in response to this open question. There was no clear difference between comments made by DCPs and dentists. Above all else, the strongest sentiment was that professionals should have flexibility to tailor their choices to their individual learning needs and field(s) of practice. Effective use of a PDP, particularly alongside a mentor, peer, or as part of an appraisal, was mentioned by many as a way to ensure individuals were better informed when choosing CPD.

Professionals commented on the need to have better exposure to what CPD was available. A few mentioned introducing a form of accreditation for CPD activities.

Some respondents made further comments about the value of retaining recommended topics, with a few suggesting that different professional groups may need a wider range of topics. Among suggestions for who else might support better choices were peer networks, professional associations, and employers.

Organisations

The range of suggestions from organisations was very broad, from developing a risk-based personal development tool and using external or peer audits, to the GDC regularly highlighting key challenges to help inform choices, as well as developing more or different requirements for specialists.

Q25. **Other organisations might be better placed to recommend CPD topics for dental professionals. Do you have any suggestions about who should be providing this information?**

Individuals

A total of 59 individuals provided a wide range of responses to this question. Approximately half of the respondents mentioned an education body of some description, including HEE, Public Health England, NES, universities, colleges, deaneries and COPDEND.

A quarter of respondents suggested that professional associations had a role to play, with reference specifically to the BDA, the DTA, the British Society of Dental Hygiene & Therapy and the British Association of Dental Nurses. Specialist societies, such as the British Orthodontic Society, were also referenced. Dental defence unions or indemnifiers were also a popular response.

Mentioned less frequently were systems regulators e.g. CQC, Health Education and Improvement Wales, and other organisations who set guidelines, such as the National Institute for Clinical Excellence or the Scottish Dental Clinical Effectiveness Programme. Some also said that peer networks such as local dental committees and employers had a role.

A few respondents reiterated the view that the GDC should continue to present recommended topics, and that the GDC alone should provide guidance on topics.

Organisations

Organisations' views were similar to those from individuals. The PDP was mentioned frequently as the central means of planning and tailoring any CPD, with emphasis placed on doing this through reflection, appraisal, mentoring, and peer support.

Nearly all agreed that there were organisations in addition the GDC who had a role to play in recommending topics. Some told us that, ultimately, it was individuals who should be responsible for their own CPD planning (the SBDN/DPA response, the OTA, and HEE) while the ADG noted that recommended topics were important and could be expanded or tailored to different groups.

The DTA was of the strong opinion that the GDC should be the sole source of recommended topics, but most other organisations responding provided suggestions as to who else could be involved.

Several organisations recognised their own role in supporting professionals with their CPD choices and described how they do so, including by developing and providing high quality CPD.

Popular suggestions of the types of organisations that might play a role included:

- Professional associations
- Royal colleges and deaneries
- HEE and equivalents
- dental defence unions or indemnifiers
- professional and specialist bodies.

Our response:

The purpose of this section was to explore who was best placed to recommend topics given that others had a better grasp of challenges facing certain groups or settings, while recognising GDC's unique role in setting standards for CPD.

It is clear to us that recommended topics have a role to play in guiding dental professionals' CPD choices (see above) and that many organisations other than the GDC already support dental professionals to make better CPD choices and to meet GDC requirements.

A future system should aim to harness the expertise of others in advising, supporting and guiding dental professionals in selecting appropriate CPD.

Q 26. Are there any final comments you would like to make about the themes explored in this discussion document, or about lifelong learning for dental professionals more broadly?

Individuals

57 individuals provided additional comments. Of these, 34 responses related to the discussion document's content. The most common point made was around the recurring theme that any scheme for dental professionals needed to be flexible and tailored to individuals' needs and settings, suit dentists and DCPs, professionals in clinical and non-clinical roles, and those with little or no patient contact, such as dental technicians working in laboratories.

A few individuals reiterated previous comments made in their responses, such as their support for a portfolio model, or their views on the minimum hours requirements and on recommended topics. A few respondents shared with us that they felt that completing CPD was not a good use of their time, or that they personally were not sure how to make CPD more meaningful. Various individuals raised the recurring theme of the need for protected and/or paid time out of work to meet CPD requirements.

A small number of individuals provided comments about the Enhanced CPD scheme, some in support of the PDP and the minimum hours requirement, others raising concerns about the inflexibility of the certification of verifiable CPD, an issue they and others also raised elsewhere in their responses.

We also received comments that were broader in scope than the discussion document, including about wider workforce and employment issues for DCPs, as well as the GDC and its relationship with dental professionals.

Organisations

Eight organisations made additional comments in response to this question. COPDEND reflected that lifelong learning needed to be presented as essential to being a professional and that it must be rewarding. UCLE called for more clarity about the GDC's preferred model for lifelong learning and called on us to set out what it would deliver and how it would be monitored. The OTA reiterated previous comments about the need to offer more support and guidance, and the need to trust dental professionals more.

HEE suggested that peer review groups could be used to support, engage, and induct dental professionals joining the register from overseas. RCSPG stressed the fact that dental professionals were employed in a wide range of roles, and therefore, a one-size-fits-all approach should be avoided. The DTA reiterated points made earlier about the need for the CPD system to support DCP career opportunities and to better acknowledge their role in the dental team.

SHP, the BDA and the SBDN/DPA made positive statements about the direction that the GDC's discussion document had taken, particularly the move towards a professionally owned, self-directed model. SHP suggested that team-based PDPs could be encouraged. They also acknowledged the challenges of creating a new system but noted that this needed to be balanced with gaining the trust of dental professionals who they said were operating in a 'climate of fear' [of regulation and litigation]. The SBDN/DPA and the BDA stressed that all roles needed to be considered, not just the clinical ones, and there was already freedom to tailor CPD to individual learning needs. The SBDN/DPA also made a comment about embedding any cultural change into undergraduate programmes, including teaching students the value of learning for trainee dental nurses and other trainees. The BDA and the SBDN/DPA were keen to support any future development of the CPD model.

Our response:

We are very pleased to see that those who engaged with this discussion on the whole supported the direction of travel towards a more flexible, learner-centred system with greater range of CPD activities that count towards any requirements which the GDC has indicated in this discussion document. We have taken away the message that we need to ensure that the system works for all settings and groups of professionals, is better able to support diverse teams and encourages the valuing of each team member's contribution.

3. Next steps

We have received a great many useful insights into professionals' and organisations' views about a potential direction of travel for a future CPD scheme. We have also heard views about the workings of the current scheme, which we have taken on board and are reflecting on.

The COVID-19 pandemic delayed our progress in responding to these views and towards developing the future system. However, we are pleased to be able to finally publish this summary and our responses to the suggestions.

The next step is to evaluate the current CPD scheme so that we can better understand which parts of the scheme work well and which do not. This is in line with our plans and was suggested by several responses to this discussion document. This will help us to assess the gap between the current scheme and the proposals in the discussion document.

This evaluation will also allow us to explore the impact of cessation of in-person CPD activities and (any) growth of online and other distance learning activities in 2020-2021, something neither we nor our respondents could have anticipated or reflected on at the time of the discussion document's publication.

Following the evaluation, we will pull together the evidence gathered so far, reflect again on the responses received to this document, and develop our proposals for a future scheme. We aim for these proposals to be tested at workshops in 2022 and consulted on in 2023.

Before we can make meaningful changes to how we operate a CPD scheme, new legislation will be needed, as our current legislative framework severely restricts our ability to amend CPD rules. The Government has recently proposed a series of changes to how all regulators of healthcare professionals operate. These changes would give us new powers in relation to setting and administering our own CPD requirements. The timetable for this reform work means that any change to the GDC's CPD scheme would not be made until 2024 at the earliest.

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