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Study concerning the review and mapping of continuous professional development and lifelong learning for health professionals in the EU

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ANNEX VII – WORKSHOP REPORT

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WORKSHOP CONCLUSIONS - SUMMARY

- Opening plenary session

To validate and elaborate on the CPD mapping study's findings, a technical workshop took place in Brussels on 20 June 2014. The workshop was intended to discuss the study's preliminary findings of the study, fill gaps in the data collected and contribute to the study's recommendations. For the occasion, there were 60 invited experts from across Europe, including representatives of national health ministries and competent authorities, representatives of European-level professional bodies, projects and networks, accreditation bodies, and academia, as well as international organisations. A variety of approaches and expectations which were presented in the course of the workshop showed the great diversity of CPD systems at individual, professional and national level, and emphasised that European cooperation fostering the exchange of good practice seemed very useful.

The workshop opened with a welcome address by Ms Caroline Hager, DG SANCO, European Commission. She outlined the EU policy context of the study, referring in particular to its relevance for the on-going activities on quality of care and patient safety, as well as in the context of mobility of EU health professionals. The implementation report of the 2009 Council Recommendations on patient safety showed that the topic was still seldom addressed in education and training, therefore Member States are encouraged to increase their efforts on this point. Also, the implementation of the Cross-Border Healthcare Directive 2011/24/EU has highlighted the need to ensure patient safety and quality of care across Europe. As regards professionals' mobility, the Professional Qualifications Directive 2005/36/EC as amended by Directive 2013/55/EU provides that Member States are to encourage CPD for health professionals, while also introducing an alert mechanism to facilitate communication on professionals' loss of the licence to practise. The CPD study was also presented as part of the Action Plan for the EU health workforce.

Following an introductory presentation of the study's preliminary findings reported by the team leader of the study, Dr Konstanty Radziwill, participants were invited to explore focus topics in greater depth in the parallel breakout sessions. Please find below a report on the breakout sessions' discussion as well as the feedback presentations in plenary.

- Patient safety: CPD and impact on daily clinical practice and quality of care: context and conditions

The breakout session was chaired by Ms Dorota Kilanska. Participants opened the discussion by pointing out that patient safety should be not only addressed by CPD activities but embedded in health professionals' practice and culture. All participants agreed that health professionals' safety is strongly connected to patient safety, as for instance in the case of infection control and medical devices. In this regard, it was noted that employers play a key role in supporting a patient safety culture at the workplace.

Participants noted that it is commonly understood that any health professional who follows CPD activities regularly contributes to patient safety. However, it is still unclear how this relation works as different systems and activities might have varying impact on professionals' practice and patient outcomes. Participants stressed the importance of looking at the quality of CPD activities and its

relation to patient outcomes, especially because there is so far not much evidence available about it. Therefore, further research to define the kind of CPD activities that relate to better patient outcomes is welcome. This will improve knowledge on how CPD systems influence patient safety, allowing further recommendations on how CPD should address it. For example, research has brought the evidence that inter-professional activities help promote patient safety. Participants mentioned that it would be also relevant to look at studies already done outside Europe, as in the United States and Canada.

The majority of participants noted that, although it is common practice to recommend patient safety in the education of health professionals, it is not mandatory yet. Therefore, they concluded that addressing patient safety within the education of health professionals (undergraduate education) should be a priority in order to contribute to the development of a patient safety culture. This conclusion was in line with the results of the Commission Second Implementation Report on the Council Recommendations on Patient Safety. Current activities that outline the content of health professionals' education should take this recommendation further (i.e. the implementation of Directive 2005/36/EC amended by Directive 2013/55/EU).

Moreover, they also agreed that learning has to come from the practice itself and that patient safety shall be understood as the outcome of every activity of professionals. Furthermore, participants suggested that health professionals could have a tool to learn and self-assess their patient safety culture and knowledge, allowing them to identify further needs and to consider patient safety part of their daily practice. The debate on the possible impact of national standards and guidelines on CPD quality of care was also relevant. It would be extremely challenging to impose a unique approach to patient safety due to different cultures, environments and needs, but promoting experiences and the best practices/models could help other countries in defining and strengthening their own system.

Participants concluded that there is a strong need for long term solutions and a broader approach to patient safety, in which CPD is a core element but not the sole one.

In the feedback session to plenary it was clarified that patient safety is already a natural outcome of CPD activities. It was also suggested that European support is needed to better share national experiences in the field, for instance having an EU level discussion on the matter would help advocating for the consequent policy decisions at national level.

- Trends: changing structures and competences

The breakout session was chaired by Dr Rita Borg Xuereb. The discussion opened with some considerations on the differences between countries where the CPD is mandatory or voluntary. The participants discussed the experiences from the perspective of different countries and different professions. Maltese participants shared the example of a breastfeeding course which was introduced to the mandatory CPD programme for midwives and the outcomes have been largely positive. One of the main discussion points was the financing / funding required to monitor the development and implementation of CPD, which is a burden once CPD is mandatory. Funding along with guidance and technological support seem to be the greatest challenges to ensure the full potential of the CPD.

Measuring CPD success includes consideration of impact on patient safety, sustainable employability of (older) health professionals, mobility (within profession) and career advancement. However there

is no evidence that mandatory CPD is better than voluntary or vice versa, moreover there is no clear evidence that CPD contributes to the positive outcomes of the patient safety. Several countries mentioned that they have mandatory and voluntary systems in co-existence to capture the benefits of both.

The discussion moved on the conditions that should be fulfilled for successful introduction of mandatory CPD and on the impact the introduction can have on the level of participation and quality of CPD. First of all, participants said that the introduction of mandatory CPD is complex and requires legislation, time, funding, guidance and technological support. Any introduction should be made with involvement of all stakeholders: professional organisations, government bodies, educators, employers, etc. The audience also pointed out that the participation must obviously be greater with the introduction of mandatory CPD. However, the difficulties in time and human resources were reported by participants as crucial factors for the professionals who work in environments where their replacement, even short-term is not an option, for e.g. those who work in rural areas or have their own small practices. Participants also agreed that high-quality content of CPD that is relevant to the professional is more important than whether it is mandatory or not.
The chair of the breakout session asked if in their opinion, participants would agree that there is a trend towards greater reliance on learning outcomes of CPD and competence assessments. Participants suggested that it is presumed that the CPD learning outcomes and competence assessments are the core in providing better quality services and care, however, they agreed that there is no clear evidence yet and further research is necessary.

Moreover, participants tried to explain how successful the attempts have been to stimulate participation in CPD and enhance positive impact of CPD on clinical practice through greater attention to the interests and ambitions of the individual professional, for instance by introducing personal development plans. They agreed that the idea behind the stimulation of the participation through greater attention to individual interests is very appealing, however this does require additional management, provision, guidance, legislation and other action which might not be compatible with the most economically efficient way to organise the CPD system.

Participants furthermore concluded that:

- There are issues arising from cross-border mobility, differences in CPD systems, different skill mix with regard to CPD depending on the country.
- There is a need for a profession-specific approach in CPD due to differences in professions (level of autonomy, career paths, gender, role of employer).
- There is a great need for CPD related to two types of competences: core (specific profession or speciality) and shared (multi-professional CPD).
- A creative approach to CPD would be beneficial: blended and flexible learning, connecting CPD to daily work and using working time could be very useful.

The outcomes of the breakout session were presented to the plenary. It was clarified that there is a need for a profession-specific approach towards modelling and implementing CPD and it is important to compel professionals to participate in high quality CPD activities. It was concluded that further research in terms of the CPD impact towards patient safety outcomes is needed. The cross-border

dimension should be considered when discussing the future of the CPD. This might be achieved, taking an example from programmes as ERASMUS +, which are based on exchange of ideas and knowledge. Using innovative methods for CPD such as eLearning were also mentioned as a potential success factor.

- Barriers and incentives: how to overcome barriers to CPD at individual/profession/regulatory level

The breakout session was chaired by Dr Martin Henman. The session opened with a discussion on the best ways to improve acceptance of the importance of CPD by an individual professional and on how it is possible to make health professionals' CPD more affordable. Participants addressed the importance of agreeing on a definition of CPD and that the content of the answers to the questions proposed may differ depending on the status of the health professional: if employed or self-employed.

Participants also agreed on the importance of measuring CPD in terms of competences. Even if the questions seemed to link the acceptance and the affordability of CPD to the individual, the audience agreed that other entities such as the employer, the ministry or the professional associations have a role to play. Participants finally decided that the acceptance and affordability of CPD is a shared responsibility of the professional, the employer and the professional association but also the ministry/department of health.

Furthermore, the discussion moved on the relevance of the impact of the lack of specifically allocated working time for CPD. Participants agreed that it is difficult to monitor CPD for professionals living in rural or isolated areas. While sometimes the lack of time to comply with the CPD is linked to shortages, it is important that the employer can allow workers to comply with the CPD within working time. The employer should also contribute to the financing of the CPD. Participants concluded that the lack of working time specifically allocated to CPD is a significant barrier. In some circumstances unfortunately this is due to the workforce shortages.

Participants were invited also to share relevant best practices of positive incentives for participation in CPD. During the discussion, three projects/studies were mentioned: a project by the Danish doctors on CPD, a study on incentives from the Belgium Health Ministry and "ECoVET", co-financed by the EU.

At the end of the day, the outcomes of the breakout session were presented to the workshop plenary. It was clarified that quite often the employers use the problem of shortages as an excuse to deny time for the CPD activities. The chair of the breakout session also reported that the CPD activities should be always take into consideration when preparing planning, in order to ensure time and necessary resources.

- Accreditation: national and European systems

The breakout session was chaired by Dr Bernard Maillet. The chair opened the meeting with a discussion on how accreditation can contribute to quality assurance and independence of CPD.

Participants agreed that accreditation can contribute to quality assurance by setting standards and relating them to patient care. Participants discussed the meaning of 'independence' of CPD activities. It was agreed that this should describe the need for activities to be free from bias, be it commercial, political or other. It was considered whether transparency, e.g. relating to the funding of an event, was sufficient to guarantee independence.

The limitations of accreditation as quality assurance were also discussed. The ex-ante nature of accreditation made it difficult to assess outcomes. At the same time it was suggested that the approach of focussing accreditation on events can be questioned, since the accreditation of the reflective cycle a professional completes, from identification of need for CPD to implementation of knowledge and skills learnt in CPD to professional practice, would be a more relevant. Experiences on reconciling national approaches to accreditation in European-level frameworks were presented by the European Union of Medical Specialists (UEMS) and the European Respiratory Society (ERS).

Participants discussed the possibility of there being a trend in terms of shifting from duration-based to outcome-based criteria in accreditation of CPD. It was accepted that while outcomes were already taken into account in accreditation processes, duration of events still played a fundamental role. It was proposed that while duration is the easiest measure, all options to enhance the standing of outcomes should be explored, in a step-by-step approach. These could include online feedback test, or feedback on professional performance. On the other hand, it was emphasised that the definition of 'outcome' was not always clear, in particular as measures such as professional performance were impacted by a great number of intervening factors beyond CPD. Also, health professionals' views may differ from health regulators' objectives as to priorities. Overall it was agreed that efforts should be made to implement an increasingly outcome-based approach to CPD.

The discussion moved on to the different ways in which accreditation bodies are regulated at national level. Participants' experiences showed that accreditation was either carried out by professional bodies with regulatory competences or (public) authorities. The Belgian example of a body bringing together the ministry of health and the profession was presented. The UK experience, on the other hand, showed that the accreditation of CPD was seen to be replaced by revalidation and fitness-to-practice assessments focussing on professional practice. It was discussed also whether the very different approaches would require some degree of reconciliation.

Following these considerations, the chair asked participants to assess if a greater role for private accreditation agencies can be expected in future and if so, how it is possible to ensure that they are guided by the need for high standards of CPD rather than by commercial considerations. Participants did not believe that private accreditation agencies are gaining importance; also the definition of 'private accreditation agency' was not clear. However the question of how to deal with conflict of interest was seen as relevant in this context. The difference between the US and the EU approach was highlighted, with reference to the US legislation on conflicts of interest of the pharmaceutical industry. The independence of accreditation agencies themselves was also addressed. Participants debated the need to accredit accreditors. It was agreed that accreditors should have to prove that they are using legitimate standards for accreditation. The separation between provider and accreditor should be ensured.

Participants discussed the advantages to accrediting the CPD event rather than the provider. The accreditation of events was criticised as disregarding the actual objective of CPD. However participants agree that its abolition would entail problems in practice. The experience of Italy's former system of accrediting both events and providers was shared. Since it proved excessively resource-intensive and complicated, the preferred approach is a national commission acting independently from the authorities which can provide certification to providers with less bureaucratic effort.

Consequently, participants discussed the benefits and challenges of European-level accreditation systems. The UEMS experience with the European Accreditation Council for CME (EACCME®) was presented. It was discussed if it is feasible to construct a similar system for other professions. The need for trust between different systems was underlined. The impact of the CPD system, e.g. whether a system is voluntary or mandatory, on professionals' choices was also highlighted as an factor which accreditation systems must be mindful of.

Lastly, participants were asked if, in their opinion, there are activities for which international accreditation is more relevant (international events, eLearning), and how it can be ensured that European-level systems complement the responsibilities of national authorities and organisations. Participants considered these questions in the broader context of European cooperation. It was discussed if the transfer of credits is feasible given the very different approaches at national level. The UEMS system based on a 'translation table' reconciling different national credit systems was presented. It was agreed that different systems can be appreciated, without excluding cooperation. With a view to the Professional Qualifications Directive's provision on CPD, it was discussed how this would impact on cross-border cooperation. It was agreed that any efforts to enhance cooperation are best driven by the profession.

The outcomes of this breakout session were presented to the workshop plenary. It was clarified that the call for closer cooperation and reconciliation of accreditation systems did not suggest harmonisation. Also in relation to conflicts of interest in the accreditation process, it was emphasised that there must be no bias in CPD activities due to industry influence. Lastly, it was clarified that while the principles of lifelong learning apply, approaches to undergraduate and postgraduate education and training must be distinguished from CPD, due to their regulatory framework and their top-down nature.

- Plenary session on European cooperation and the cross-border dimension of CPD

The plenary discussion turned to a panel debate on European cooperation and the cross-border dimension of CPD, addressing in particular how European cooperation on CPD is relevant and which examples of CPD/LLL activities in their own experience may already reflect a European dimension. A representative of the Latvian Nurses Association shared her experience as a health professional of the post-Soviet transition of the Latvian healthcare system, during which the Latvian professional bodies had benefited from European cooperation to develop national policy, i.a. on CPD. To highlight the relevance the European dimension even today, she reported of recent projects in which financial support from the European Social Fund had enabled professionals to follow CPD activities. She also welcomed the multi-professional approach of the study's discussions as an innovative and fruitful format for advancing policy.

A representative from the European Network of Medical Competent Authorities was invited to present the regulators' view on European cooperation. He reported that the network, which was set up in the context of the revision of the Professional Qualifications Directive, found that competent authorities face common questions as regards professionals' CPD activities and the recognition of qualifications. On this basis information on CPD systems was collected. He suggested that while information on CPD was useful for the recognition process, it was not feasible to integrate it into the requirements for recognition, much less giving it an 'automatic recognition' status. Similarly he saw problems for accreditation of CPD to be taken out of the national to the European level.

A representative of the European University Association presented the educators' perspective. He related that despite the interest and degree of involvement of faculties in CPD, the topic was rarely addressed by universities' executive bodies, which consequently entailed a weaker degree of cooperation. For example, there are no 'Bologna' type initiatives on CPD. Nonetheless, the European University Association adopted the 'European Universities' Charter on Lifelong Learning' in 2008 which sets out the commitment to improve structures and learning cultures to take the LLL agenda forward. He also referred to other European frameworks on qualifications as well as education and training, which were gaining attention, such as the reference to the European Credit Transfer System in the Professional Qualifications Directive. Lastly he shared some impressions on quality assurance, where increasing emphasis is on learning outcomes. This is also reflected in the revision of the European Credit Transfer System.

The plenary was invited to comment on possible forms of European cooperation and discuss what added value it can provide. Participants considered how European cooperation relates to national policies. Participants felt that the diversity of approaches to CPD excluded harmonisation at European level, therefore cooperation should focus on exchanging good practices to strengthen national systems, in particular as most professionals spent their entire careers in their home Member State. On the other hand it was suggested that small countries in particular stood to benefit from enhanced cross-border cooperation, given the opportunities this opened if the national-level profession is numerically small in size. Experiences with existing frameworks, e.g. on accreditation, were shared. It was clarified that CPD was not a qualification, but rather a professional responsibility, based around the individual professional and driven by the individual professional's reflection on the limits of current skills and knowledge. It should therefore not be viewed in terms of frameworks, which are qualifications-based, e.g. automatic recognition or curricula. However, other participants also felt the need to encourage and support health professionals to tackle that responsibility, above all in terms of available time and resources, and employers play a key role in this regard. It was noted that where requirements and structures are put in place this can contribute to allowing health professionals to follow CPD and therefore be useful.

The relevance of EU instruments was also addressed. Participants welcomed the idea of using EU funds for research into or the implementation of CPD. The need for more research on the impact of CPD on quality of care and patient safety was mentioned as a potential focus for research, as was additional research on CPD systems across Europe. Applying EU frameworks on skills and qualifications to CPD was viewed as a more complex question. The large number of tools and the lack of clarity on their interrelation were seen as a barrier to a better use of these mechanisms.