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

Contract no. 2013 62 02

[D.4 FINAL REPORT]

ANNEX III B - EUROPEAN INITIATIVES ON CPD AND LLL

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Abbreviations

CE	Continuing Education
CED	Council of European Dentists
CME	Continuing Medical Education
CPD	Continuing Professional Development
CHAFAEA	Consumers Health and Food Executive Agency
CPME	Standing Committee of European Doctors
CVET	Continuing Vocational Education and Training
EC	European Commission
ECTS	European Credit Transfer System
ECVET	European Credit System for Vocational Education and Training
EEA	European Economic Area
EFN	European Federation of Nurses' Associations
EFTA	European Free Trade Association
EMA	European Midwives' Association
EPHA	European Public Health Alliance
EQAVET	European Quality Assurance in VET
EQF	European Qualifications Framework
EU	European Union
GMC	General Medical Council
HCPs	Health Care Professionals
IE	Inter-professional Education
LLL	Lifelong Learning
NQF	National Qualifications Framework
OECD	Organisation for Economic Co-operation and Development
PGEU	Pharmaceutical Group in the European Union
UEMS	European Union of Medical Specialists
UK	United Kingdom
VET	Vocational Education and Training
WHO	World Health Organization

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Introduction

European health systems are intrinsically complex and subject to growing pressures, *inter alia* due to demographic change and concomitant increases in chronic diseases, professional shortages and skill mismatches, and increased private sector involvement as a result of budget squeezes. Continuous professional development (CPD) is situated at the confluence of many European Union (EU) policy areas including, *inter alia*, education and training, employment, mobility and migration, research and technological innovation. Seen as an approach to Lifelong Learning (LLL), the development of CPD is also being shaped by broader shifts occurring in LLL, in particular the move towards focusing on learning outcomes rather than on length of study or training.

Ensuring quality of care and patient safety is a crucial goal shared across European healthcare systems. This realisation is not only stimulating discussions about international alignment of CPD but has also led to a whole array of European initiatives that seek to provide quality assurance and accreditation of education and training activities at all levels. They encourage increased transparency, comparability and permeability of qualifications and other knowledge, skills and competences acquired throughout professional careers in the context of mobility. One of the principal purposes of these initiatives is to create trust, amongst regulators, employers and professionals, that whatever is being undertaken as CPD in one country will correspond to the professional standards and expectations of another country's labour market and healthcare system, thereby making it easier to recognise formal and informal learning that may contribute to any programme for maintaining professional qualifications.

This second literature review is part of the Consumers, Health and Food Executive Agency (CHAFEA) study concerning the review and mapping of CPD and LLL for health professionals in the EU-28 Member States and EEA/EFTA countries. It complements the first inventory, which established a reference framework for the study by focusing on CPD terminology relevant to the discussion and pertaining to the five sectoral health professions falling under this service contract (i.e., doctors, nurses, midwives, pharmacists and dentists). It also became apparent from the first literature review that CPD for health professionals is already commonplace, and that it is frequently likely to be a legislative or regulatory requirement for many health professionals in the EU. In some cases it is linked to recertification / revalidation of the health professional's continued entitlement to practice.

The specific objective of the present review is to examine more closely the European, cross-border dimension of CPD/LLL initiatives, whether led by the European Commission (EC) itself, the five sectoral professions or by other actors, with the aim of identifying elements and trends that may be indicative for the future development of CPD in the five health professions. The following research questions have guided the study:

1. What initiatives on CPD and LLL are carried out at the EU level?
2. What initiatives on CPD and LLL exist at European level outside the EU context?
3. What aspects of CPD and LLL are addressed by these initiatives (e.g. relating to accreditation, transparency, quality, transferability)?
4. How do these initiatives come into being (motivation, actors involved, process)?
5. How do these initiatives relate to national systems?

Put together, the two literature reviews aspire to draw a varied picture of what has been written about health professionals' CPD in Europe including also developments in related sectors, thereby providing valuable background information for the subsequent stages of the study including the recommendations that will be part of the final report.

As mentioned in the previous literature review, CPD and LLL as concepts are not regulated or well defined at the European level. The interim outcomes of the research undertaken by the study

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consortium confirm the findings of the literature that CPD in the sectoral health professions is multifaceted and subject to a wide array of regulatory regimes across Europe - whether mandatory or voluntary systems or lack of CPD mechanisms - with big differences between countries and professions, and blurred boundaries in some cases. This diversity is a direct consequence of the complexity of healthcare itself, including its provision and regulation at national level.

The first literature review also revealed a consensus across the health professions that CPD is a necessary part of professional practice – indeed a professional responsibility - not least in order to keep knowledge, skills and competences up-to-date and thereby ensure the best possible quality of care and protect patients. CPD asserts itself as soon as formal health professional qualifications have been attained.

The present literature review establishes that, in spite of many European-level initiatives established by the EC and other stakeholders, there is a lack of evidence on how they could relate more concretely to developing CPD across Europe. This is due partly to insufficient data about CPD providers in health (e.g. the percentage currently delivered by higher education institutions as opposed to by VET institutions, professional organisations, employers and other stakeholders). It also remains unknown what kind of impact the development of competence-based curricula in health professional programmes might have on future CPD, patient safety / quality of care, and skills development.

The available literature does however reveal that existing EU instruments were designed for specific purposes and contexts, which makes them difficult to replicate for the purposes of health professional CPD where national specificities regarding health system and educational processes remain important. The experiences drawn from projects in the area of vocational education and training and on the use of credit transfers are nonetheless insightful when it comes to envisaging the future of CPD in an increasingly cross-border healthcare context.

Methodology

The literature review was conducted primarily online using a focused approach on European CPD and LLL initiatives, scrutinising academic articles, relevant organisational and project websites and reports by European Institutions and professional bodies active at EU, national and regional level, policy documents, existing legislation, as well as non-academic and grey literature.

As for the first literature review, the PubMed and MEDLine databases were used, as well as the research database of Lancaster University Library, United Kingdom (UK). The EAHC projects database was searched for projects between the years 2003 and 2013 and the Community Research and Development Information Service (CORDIS EU) research portal was reviewed for all projects within the fifth, sixth and seventh EU research frameworks, as well as other relevant programmes.

Moreover, the specific legislation and policy initiatives mentioned in the tender specifications and inception report were reviewed and a search of EU websites was conducted for other relevant documents and resources. The EC's (EC) Central Library was consulted during a visit in March, 2014 to identify further sources. In addition, multiple searches of Google and Google Scholar were conducted, taking in each case the first five pages of results. Finally, time was dedicated to following up leads discovered during the initial searches.

Following the logic of the first inventory, the search strategy identified a number of key terms, which included the use of the variants of CPD and LLL applicable to the five health professions described previously in combination with more specific search terms such as 'learning outcomes', 'quality assessment', 'accreditation', 'mobility', 'ECVET/EQF/ECTS', etc. These were then coupled with broader search terms such as 'health', 'education', 'employment', and 'Europe'.

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In addition to the desk research, a number of **consultations with European stakeholders** were held with individuals engaged in CPD and LLL, identified by the consortium partners and in collaboration with the European Commission. These dialogues were necessary to clarify a number of points and obtain more practical input into the interrelationships of the instruments discussed since overall, the guiding questions for this inventory are insufficiently explored in the literature. A meeting in London in early 2014 between the leaders of this literature review helped define a number of guiding questions the experts were provided with to make the study more 'concrete' (see Annex 2). Most stakeholders felt that not all questions applied to them and therefore the focus was on identifying trends and any additional issues respondents felt needed addressing. The individuals consulted include representatives of accreditation bodies, the Commission's Directorate-Generals (DGs) Education and Culture and Markt, providers, professional bodies and academics, based in Brussels and elsewhere in Europe. The consultations took the form of face-to-face conversations, telephone and e-mail communications about relevant CPD developments and mechanisms. They varied greatly in length and scope.

The review also includes input by the members of the study's **Expert Reference Network**¹. The purpose of these consultations was to substantiate the outcomes of the inventory and fill any knowledge gaps.

Finally, given the interplay between European and national level CPD initiatives, searches were conducted in EU languages other than English², using translations of the key terms and language or region specific functions of the target databases and websites.

Inclusion / exclusion criteria and limitations

Given the dynamic nature of policies and their impacts on education, mobility and employment, the literature review excluded all resources published before 1990, while giving clear preference to the most recent data available since many sources from the pre-2000 area were found to be outdated. The focus was on Europe-wide initiatives, projects and studies of relevance in a CPD and LLL context, however some international and national sources were included. Most up-to-date information was found on European Institutions' websites and on those of professional bodies involved in national or international quality assurance of CPD.

This inventory went beyond the more narrow scope of the first review by looking at other professional areas, such as the engineering and nuclear sectors, to see if initiatives in these disciplines could contain lessons for CPD in health. The review also included the non-sectoral health professions, however it is beyond the scope of this paper to list all CPD initiatives undertaken in e.g. the medical specialties (urology, etc.) linked to the UEMS-EACCME® system described below.

Overall, the inclusion criteria reflected the stated role of this inventory as a supporting tool for the remainder of the study and priority was given to sources that provided answers to the main research questions listed above.

Regarding the limitations, the main observations of the first review remained applicable, i.e. most up-to-date information is available on websites rather than in article/book format, the majority of sources originate in a minority of European countries, and there is a strong bias based on country of origin, profession and attitude towards CPD/LLL in general. In addition, the research was complicated by the fact that few sources specifically address the interplay between CPD/LLL developments and European

¹ The members of the Expert Reference Network are listed in the Inception Report of the project, and further information on its activities will be provided in the Final Report.

² Attempts were made to find relevant sources in French, German, Spanish, Italian, Dutch, Romanian, and Portuguese. It was then extended to the remaining EU/EEA languages; however, little appropriate information could be identified for the vast majority of these languages.

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transparency tools for education and labour market purposes. Many of the initiatives described below are policy oriented and project based and there is little academic literature specifically providing a critical viewpoint on their potential value for CPD/LLL.

Since the focus on initiatives with a European scope almost inevitably implies that outcomes are being reported in English, the available literature showed an even stronger bias towards English language sources than literature examined during the previous review where many national sources were found.

Finally, there was a noticeable bias in the sense that relevant discussions most frequently took place in the context of doctors' continuing education, thus in the framework of 'CME-CPD'. This was balanced out by focusing on broader LLL initiatives likely to be of interest to all five health professions.

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European policy context

Since the majority of CPD is undertaken to improve health professionals' knowledge, skills and competences within the national health systems they are operating in, and the organisation of these and of professional education and training remains a Member State competence, it is not surprising that CPD of health professionals occupies a marginal position in EU policy. At the same time though, a number of legislative mechanisms are in place at European level to facilitate and manage health professional mobility, and cross-border cooperation is underway for improving patient safety and quality of care. These mechanisms are summarised below.

Following the signing of the Treaty of Rome in 1957³, the comparison and assessment of professional qualifications has been a central concern in Europe, closely connected with the principle of free movement and encouraging high educational standards. The 1992 Maastricht Treaty has intensified this work and mobility has become one of the pillars of EU citizenship⁴. However, the first European Mobility Scoreboard⁵, published in January 2014 by education statistics network *Eurydice*, reveals big differences in national mobility initiatives in higher education. The scoreboard covers all EU-28 Member States, as well as Iceland, Norway, Liechtenstein and Turkey. It is a first overview of the factors covered in the 2011 Council Recommendation on learning mobility⁶ and will be a basis for future joint monitoring at EU level. It allows comparison of data and indicators in areas including the recognition of learning outcomes and access to grants. Although the findings do not include information on CPD, two general observations are of interest in the context of this study. Firstly, they reveal that mobility is not a 'given', especially for students with disadvantaged backgrounds (Mundell, 2014) and secondly, only three countries (BE, DE, ES) were found to make considerable efforts to monitor the use of European tools including the European Credit Transfer and Accumulation System (ECTS, see below) and Diploma Supplement that facilitate recognition of studies and training abroad.

In a similar vein, better monitoring the implementation of CPD developments in the health sector, and highlighting best practices and access barriers (e.g. requiring health professionals to pay), could be one way to ensure that health professionals across Europe have the opportunity to undertake CPD.

Professional Qualifications Directive

Health professionals are among the most mobile workers in Europe. Commentators have argued that problems related to the mutual recognition of qualifications are primarily a consequence of different European education systems and approaches to learning (Calendini & Storai, 2002). While national education systems do not seek full harmonisation, European legislation on the recognition of professional qualifications based on minimum training requirements is facilitating freedom of movement.

Directive 2005/36/EC as amended by Directive 2013/55/EU (from here on referred to as the revised Directive on the Recognition of Professional Qualifications)⁷ stipulates European rules for the recognition of qualifications establishing common grounds of education which apply to professionals wishing to practise their profession in another Member State (whether as self-employed or as

³ Compare Title III, Chapter 1, 'Workers', and Chapter 2, 'Right of Establishment', http://ec.europa.eu/archives/emu_history/documents/treaties/rometreaty2.pdf

⁴ For example, it stipulates the right to move and reside freely on the territory of the Member States:

⁵ See also EC Press Release 'European Mobility Scoreboard: Frequently Asked Questions', http://europa.eu/rapid/press-release_MEMO-14-7_en.htm

⁶ Council Recommendation of 28 June 2011, 'Youth on the move' — promoting the learning mobility of young people (2011/C 199/01), <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2011:199:0001:0005:en:PDF>

⁷ Directive 2013/55/EU of the European Parliament and of the Council of 20 November 2013 amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation (EU) No 1024/2012 on administrative cooperation through the Internal Market Information System ('the IMI Regulation'). See <http://eurlex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2013:354:0132:0170:en:PDF>

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employee) and provide services in their field. Depending on profession, the Directive provides different routes to recognition of professional qualifications. This includes **EU-wide automatic recognition**, applicable in the case of the sectoral health professions, and the so-called general system which gives a great degree of discretion to the Member States in making case-by-case decisions, including for other regulated health professions. For temporary/occasional activity no formal prior qualifications checks are required although they may be maintained for professions with public health implications. The revised Directive is currently in its transposition phase until January 2016⁸ and the necessary conditions within most Member States and the EU institutions for its implementation have not yet been attained.

Crucially, the Directive's preamble recognises the **increased importance of lifelong learning** to keep abreast of technical and scientific progress. Article 22 explicitly 'encourages' CPD for the five health professions investigated here to maintain safe and effective practice⁹ and requires Member States to report to the Commission the measures taken to promote CPD for the professions benefitting from automatic recognition, and, under Article 56, 'to exchange information and best practices for the purpose of optimising continuous professional development in Member States'.

The inclusion of CPD in the Directive in a non-coercive fashion is deliberate; it demonstrates the important distinction between the *recognition* of professional qualifications under the automatic recognition regime and *granting access* to health professions. While the recognition decision is regulated under the EU Directive, the granting of a licence to practise or inclusion in the national professional registry is subject to national regulation, legislation and competence. Lack of CPD thus cannot be a barrier for the recognition of qualifications according to the Directive, but it **can play a role for maintaining access to the profession to demonstrate fitness to practice**.

The Directive also makes specific reference to the **LLL principle** in the context of the relation between the European Qualifications Framework (EQF, see section 2) and the categorisation used for professions under the general system (recital 11).

The **introduction of EQF and optional inclusion of the European Credit Transfer and Accumulation System (ECTS)** – the sectoral professions may now express course durations in ECTS credits (Davies, 2014) – testifies a growing interest in applying transparency tools (see below).

Other provisions of interest include recital 13 on **compensation measures** for professions falling under the general system where, unlike for the sectoral health professions, there are no harmonised minimum training conditions and individuals need to submit proof of professional competences.

Finally, recital 20 refers to the **evolution of the nursing profession**, and it stipulates that training should provide robust, *output-oriented* assurance that professionals have obtained certain knowledge and skills during the training.

Cross-border Patients' Rights Directive

Under the Directive on patients' rights in cross-border healthcare (2011/24/EU)¹⁰, which had to be transposed by October 2013, cross-border healthcare is to be provided in accordance with standards laid down by the Member State of treatment (Article 3). Nevertheless, Member States are encouraged to cooperate with each other, including on **standards and guidelines on quality and safety** (Article 10). This might also encourage increased cooperation on exchanging information about CPD.

⁸ As per the Directive, the transposition deadline is 18 January 2016.

⁹ Recital 15 of Directive 2013/55/EU makes specific mention of encouraging CPD for medical specialists, general practitioners, nurses responsible for general care, dental practitioners, specialised dental practitioners, veterinary surgeons, midwives, pharmacists and architects.

¹⁰ Directive 2011/24/EU, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:EN:PDF>

Article 6 of the Directive requires the setting up of **National Contact Points** so that patients can receive relevant information on the safety and quality standards enforced in the Member State of treatment, including on which healthcare providers are subject to these standards.

Moreover, the new **European Reference Networks** as per Article 12 of the Directive will act as focal points for (medical) training and research, information dissemination and evaluation. The voluntary exchange of best practices between healthcare providers and centres of expertise to build innovative health professional practice and provide professional training might potentially benefit CPD by combining expertise derived from applied and high level academic knowledge. Part and parcel of the work of European Reference Networks will also be to encourage the development of quality and safety benchmarks.

In the context of the Directive, the Evaluating Care Across Border (ECAB) project¹¹ under FP7 (May 2010 - October 2013) was undertaken by partners across 11 Member States to facilitate a process that enables European citizens to make informed choices about seeking healthcare in another Member State, including administrative and clinical aspects, and to safeguard continuity of care. It focused on areas where information gaps were identified, such as provisions regarding the quality standards in place for health professionals. More specifically, the ECAB work package on health professionals included a mapping exercise to

- identify Europe-wide medical professional bodies engaged in the development of guidelines and standards;
- describe the procedures for maintaining professional standards in each Member State;
- assess the criteria used in disciplinary measures taken against physicians;
- describe the scope of practice, skills and experience of designated specialists in EU Member States, and
- describe the mechanisms for redress (legal and administrative) in the event of med

A 2013 issue of *Eurohealth* discusses ECAB project findings with a dedicated chapter on 'processes and regulatory procedures of doctors in the European Union' (Risso-Gill et al., 2013). It begins by explaining that, although the Directive on the Recognition of Professional Qualifications 'assumes that all doctors sharing the same qualifications also share the same competencies and meet the same professional standards (...) the diversity in training and registration procedures suggests that this is unlikely to be the case' (ibid.:6). The authors argue that little is known about the training, practise and regulation of physicians in different countries, as well as pertaining to their competencies. Moreover, due to different processes regarding registration and licensing, which 'vary in content and applicability' across Europe, they conclude that the professional standards used for determining fitness-to-practise, and disciplinary processes to regulate them, are dissimilar. This could have an impact patient safety and quality of care and widen the gap between patients' expectations and reality.

Action Plan for the EU Health Workforce

In addition to the Directives mentioned above, CPD could play a role in making the health professions more attractive in the context of creating sustainable health workforces across Europe.

According to the 2012 Communication 'Towards a job rich recovery'¹², the development of LLL is vital to achieving security in employment and employers should guarantee access to training opportunities, particularly for lower skilled workers and vulnerable groups. The economic crisis has led to a polarisation of jobs into low and high quality blocks and LLL, encompassing CPD and other forms of learning, has potential to counter this trend.

¹¹ www.ecabeurope.eu

¹² COM(2012) 173 final

The Communication contained a **Staff Working Document on an Action Plan for the EU Health Workforce**¹³. The Action Plan represents a response to the priorities identified in the Council Conclusions on investing in the health workforce¹⁴ and the feedback from the Commission's Green Paper and consultation on a European Workforce for Health¹⁵.

Its purpose is to assist Member States in tackling urgent health workforce challenges by outlining key actions to foster cooperation and share good practices. The plan contains proposals for improving planning and forecasting; anticipating future skills needs; improving recruitment and retention; and mitigating the effects of migration on health systems. The present study results from the Action Plan and supports health system sustainability by linking CPD to the plan's focus on avoiding future skills mismatches and shortages in the health sector.

The plan's first area of action includes a **Joint Action (JA) on forecasting and planning** under the Health Programme. According to its web pages¹⁶, the JA's general objective is to function as a platform for collaboration and exchange between Member States to prepare the future of the health workforce. This will support them and Europe in their capacity to take effective and sustainable measures. Various tools will be developed to implement health workforce planning and/or enhance current processes. One action involves developing guidance on the exchange of education and training capacities in health professions in order to make best use of them, based on a mapping study of Member States, particularly regarding medical universities and nursing schools.

The second area of action, 'anticipation of skills needs', involves creating partnerships between education and vocational training providers and employers in the healthcare sector via a pilot **Sector Skills Alliance**. This includes the promotion of exchanges of good practices on CPD, as well as updating skills and competences and helping retain healthcare personnel through LLL, objectives to which the present study is contributing.

The third area for European cooperation is to 'stimulate exchange on recruitment and retention' comprises a **mapping of innovative and effective recruitment and retention strategies** with a view to exchanging good practices. A study is currently underway and member of the consortium were consulted as part of the present analysis (see section on 'European perspectives on CPD').

The Commission has set up an expert working group composed of representatives from the Ministries of Health and health professional bodies which meets twice a year to discuss European cooperation to address the challenges facing the health workforce and actions to address these within the framework of the action plan for the EU health workforce.

European patient safety initiatives

The role of CPD to help safeguard patient safety provides a specific focus of this study in light of increased cross-border mobility of both patients and health professionals. The question as to whether CPD enhances patient safety should be the cornerstone of quality assurance processes.

The 2009 **Council Recommendation on Patient Safety and Quality of Healthcare**¹⁷ recognises poor patient safety as a public health problem which can drain health system budgets. It calls on

¹³ 'SWD(2012) 93 final, http://ec.europa.eu/dgs/health_consumer/docs/swd_ap_eu_healthcare_workforce_en.pdf

¹⁴ Council conclusions on investing in Europe's health workforce of tomorrow: Scope for innovation and collaboration. 3053rd Employment, Social Policy Health and Consumer Affairs Council, 7 Dec 2010,

http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/118280.pdf

¹⁵ COM(2008) 725 final, http://ec.europa.eu/health/ph_systems/docs/workforce_gp_en.pdf

¹⁶ <http://euhwforce.weebly.com/>

¹⁷ Council Recommendation of 9 June 2009 on patient safety, including the prevention and control of healthcare associated infections, 2009/C 151/01, http://ec.europa.eu/health/patient_safety/docs/council_2009_en.pdf

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Member States to incorporate patient safety as a priority issue into health policies and programmes at all levels. New technology shall support safe and user-friendly systems, and the development of core competencies in patient safety including 'knowledge, attitudes and skills' is also proposed.

The education and training of healthcare workers is highlighted in point 4 of the Recommendation which encourages 'multidisciplinary patient safety education'. Patient safety should be a component of all career stages, i.e. 'in undergraduate and postgraduate education, on-the-job training and the continuing professional development of health professionals'. Collaboration and information exchanges between professions, patient organisations and education providers should take place regarding standards, competencies, and patient safety outcomes.

The **two implementation reports**^{18,19} by the EC to the Council found that Member States were poor in implementing the Recommendation. The second report from June 2014 found that patient safety in the education and training of healthcare workers 'remains under-implemented' and only six Member States had it embedded as part of academic, on-the-job or CPD learning.

The **EU Network for Patient Safety and Quality of Care (PaSQ)**²⁰ is a Joint Action (2012-2015) between the EC and Member States co-funded under the Public Health Programme. It brings together Member States' health authorities, representatives of the EU health professional community (doctors, nurses, dentists, pharmacists, managers), patient associations, and international organisations. It collects and facilitates the exchange of best practices and organises exchange mechanisms for improvements at the healthcare organisation level, and quality of care at national or regional level.

Additionally, the EC **Patient Safety and Quality of Care Working Group (PSQCWG)**²¹ assists in developing the EU agenda in this area. A subgroup of the High Level Group on Health Services and Medical Care established in 2004, it brings together representatives from EU-28/EFTA countries, patients, health professionals, international organisations, EU bodies and other stakeholders. In 2014, it published a report presenting 'key findings and recommendations on education and training in patient safety across Europe'²². The latter document discusses the organisation of available programmes (ownership, governance, national regulations, target audiences, types of education, evaluation) and analyses content in terms of learning outcomes. It recommends the following points:

- Patient safety should be introduced and implemented in the curricula for healthcare workers and managers in every Member State
- It should take place at all levels of healthcare professionals' and managers' learning and development
- It should be based on previous European projects and WHO work in the area of building / developing curricula
- It should find constructive, feasible and effective ways to include the perspective of patients when developing curricula on patient safety
- Curricula should be adapted to each country as patient safety cannot be a static programme

¹⁸ Report from the Commission to the Council on the basis of Member States' reports on the implementation of the Council Recommendation (2009/C 151/01) on patient safety, including the prevention and control of healthcare associated infections COM(2012) 658 final.

¹⁹ Patient Safety and Healthcare-Associated Infections, Report from the Commission to the Council, June 2014, available at http://ec.europa.eu/health/patient_safety/docs/ec_2ndreport_ps_implementation_en.pdf, p.4

²⁰ PASQ network, <http://www.pasq.eu/>

²¹ For more information on the PSQCWG, see http://ec.europa.eu/health/patient_safety/events/index_en.htm

²² http://ec.europa.eu/health/patient_safety/docs/guidelines_psqcwg_education_training_en.pdf

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Relevant EU initiatives in the context of CPD and LLL for health professionals

As mentioned in the introduction, the sectoral health professions differ from many other professions as a result of their high degree of mobility in the EU. This is reflected by the special status conferred upon them in the revised Directive on the Recognition of Professional Qualifications. The health and safety dimension of these professions is another critical factor that sets them apart.

However, mobility is not the only element that makes the health professions unique. They are highly regulated, licensing plays an important role, and they also distinguish themselves by the way their education is organised. The integration of academic and workplace learning is necessary in order to advance and gain access to the profession, which means there is a continuum of learning from undergraduate to postgraduate level followed by CPD. In this way, the gradual increase in skill acquisition and competence development alongside specialist knowledge is more important and concrete than in many other professions. Given the diversity of national and regional health system contexts in which practical learning takes place, it becomes arguably more challenging to establish the *equivalency* of qualifications attained. CPD complicates this further as it is an individualised process of lifelong learning rather than a qualification.

Broadly speaking, CPD and LLL are situated within evolving European education and training policies that are taking shape in response to challenges experienced in all Member States including education and labour market changes, rapid technological developments, market changes and organisational evolution, requiring individuals to build up flexible, transferable skills while being increasingly mobile (Colardyn & Bjornavold, 2004). The governance of education and training is becoming increasingly complex and multilevel, including 'an extensive list of collective actors enlisted into the LLL cause' (Gaió Alves, Neves & Gomes, 2010:333) which, alongside the EU, include transnational, national, regional and local bodies, social and professional organisations and labour market stakeholders.

European educational cooperation, as outlined in the 'Strategic Framework for European Cooperation in Education and Training'²³ is a way of developing joint solutions that support the goal of the Lisbon Strategy to make Europe the most competitive and dynamic knowledge-based economy in the world by 2020 (Küßner, 2012; Lazăr & Lazăr, 2012). Article 165 of the Lisbon Treaty²⁴ explicitly states that 'the Union shall contribute to the **development of quality education by encouraging cooperation between Member States** and, if necessary, by supporting and supplementing their action, while fully respecting the responsibility of the Member States for the content of teaching and the organisation of education systems and their cultural and linguistic diversity.'

Since the 2000 Lisbon Council, the 'open method of coordination' has been one way of driving forward convergence through the establishment of European standards and benchmarks Member States are free to adopt (Dehmel, 2006). The objectives of the Strategic Framework demonstrate the growing role of international transparency and comparability of learning activities:

1. Making lifelong learning and mobility a reality;
2. Improving the quality and efficiency of education and training;
3. Promoting equity, social cohesion, and active citizenship;
4. Enhancing creativity and innovation, including entrepreneurship, at all levels of education and training.

²³ http://ec.europa.eu/education/policy/strategic-framework/index_en.htm

²⁴ Lisbon Treaty full text available at http://europa.eu/lisbon_treaty/full_text/index_en.htm

LLL thus plays a growing role in EU education policy, as testified by the EC Communication, 'Making a European Area of LLL a Reality'²⁵, followed by a 2002 Council Resolution²⁶. Seen as an instrument for change (Jarvis, 2007), LLL helps transform and modernise education systems but also transfers more learning responsibility on individuals. It has been argued that LLL policies serve both economic and social development / citizenship goals (Gaio Alves, Neves & Gomes, 2010). The Commission's LLL approach²⁷ takes a holistic view, i.e. it comprises all general and vocational education and training, as well as non-formal education and informal learning that lead to improvement in relevant knowledge, skills and competences. This definition of LLL is also included in Article 3 of the revised Directive on the Recognition of Professional Qualifications.

The first literature review already drew the distinction between LLL and CPD. If seen as part of a broader LLL strategy that strives to create a learning society (Shaw & Green, 1999), it is part of a self-motivated learning process that begins at school and continues throughout professional careers. Hence it is important to create mechanisms that ensure its quality and appropriateness.

A number of EU initiatives and instruments, introduced as part of higher education and vocational education and training (VET) policy within LLL, provide ideas, tools and approaches that merit further consideration for CPD, especially in the context of debates over EU-wide assessment and validation (but less so when it comes to CPD organisation at national level). The shift to **learning outcomes** (Cedefop, 2009) at different levels of education has been noted as an opportunity to illuminate the relationship between different instruments and explain how they work to open up qualification systems (Bjørnåvold & Le Mouillour, 2009). The initiatives described below also highlight how non-formal and informal learning - an important part of the CPD of some sectoral health professions - could be validated and integrated into such systems (Colardyn & Bjørnåvold, 2004).

Overall, the EU initiatives support the process of building a **European Area of Skills and Qualifications** (EASQ) that would allow easy comparison and recognition of skills and qualifications and simplify employment procedures for individuals and businesses. EASQ links learners' personal development with economic objectives in an efficient European Single Market. A recent public consultation²⁸ sought to collect stakeholders' views on the problems faced by mobile professionals pertaining to the transparency and recognition of their skills and qualifications, the adequacy of EU policies and instruments, and the potential benefits of an EASQ. It also dealt with other issues of interest to CPD, i.e. internationalisation trends, policy coherence, compatibility of tools, and quality assurance.

Within the context of mobility, **building up mutual trust** between providers, employers and learners has been identified as being particularly important since 'the aim is for standardised instruments and procedures and evaluation indicators to facilitate communication and understanding (...) across systems and national borders, as well as bringing about an increase in the quality of educational provision by improving recognition and permeability' (Küßner, 2012:46).

European Credit System for Vocational Education and Training (ECVET)

The 1999 Bologna Declaration provided the starting point for the advancement of EU-wide mobility and transparency in the field of education. In higher education, this has been achieved through the

²⁵ COM(2001) 678 final, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2001:0678:FIN:EN:PDF>

²⁶ Council Resolution of 27 June 2002 on lifelong learning, 2002/C 163/01, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2002:163:0001:0003:EN:PDF>

²⁷ In the years 2007-2013, the EC's LLL approach was principally implemented through the LLL Programme and the Education and Training 2010 programme

²⁸ http://ec.europa.eu/dgs/education_culture/more_info/consultations/skills_en.htm

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Bologna Process. While the latter has clearly had a profound impact on the reform of European higher education systems and its three cycle degree structure has been widely adopted across Europe in most academic disciplines, the field of medicine represents an exception to the rule. A study 'evaluating the Professional Qualifications Directive against recent educational reforms in EU Member States' undertaken for the European Commission's Directorate-General MARKT (GHK, 2011) reveals that medicine is not part of the Bologna degree cycles in 16 EU Member States. In these countries, as a result of labour market specificities and different lengths of study, integrated programmes remain in place.

In the area of vocational education and training (VET), a number of processes stimulated similar developments. The Lisbon Strategy included common objectives to improve Member States' education and training systems in the transition to a knowledge society, including better transparency of qualifications. The 2002 Barcelona European Council and the ensuing Copenhagen process²⁹ called for renewed cooperation in the area of VET, and further support was provided by 2008 Council Conclusions³⁰. These high profile statements have led to the creation of new framework for the validation of VET, which is being continued in the context of the Bruges Communiqué and the Education and Training 2020 programme³¹, and in response to 2009 Council Conclusions on a strategic framework for EU cooperation in education and training³².

One of the most tangible outcomes of European VET cooperation is the European Credit System for Vocational Education and Training (ECVET), described on the EC website³³ as

(...) a common methodological framework that facilitates the accumulation and transfer of credits for learning outcomes from one qualifications system to another. It aims to promote transnational mobility and access to lifelong learning. It is not intended to replace national qualification systems, but to achieve better comparability and compatibility among them. ECVET applies to all outcomes obtained by an individual from various education and training pathways that are then transferred, recognised and accumulated in view of achieving a qualification.

The ECVET's value, created following a 2009 Recommendation³⁴ by the European Parliament and Council and used by the Member States since 2012, is that it enables skills and knowledge acquired by citizens in a variety of settings (school- or work-based training undertaken at home or abroad) to be recorded and assessed. While it is specifically designed for VET, there is an understanding that VET qualifications can be at any level, including at a very high level.

²⁹ http://europa.eu/legislation_summaries/education_training_youth/vocational_training/ef0018_en.htm

³⁰ Council Conclusions on the future priorities for enhanced European cooperation in vocational education and training (VET). http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/educ/104234.pdf

³¹ http://europa.eu/legislation_summaries/education_training_youth/general_framework/ef0016_en.htm

³² Council Conclusions on a strategic framework for EU cooperation in education and training, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:119:0002:0010:EN:PDF>,

³³ Compare at http://europa.eu/legislation_summaries/education_training_youth/lifelong_learning/c11107_en.htm

³⁴ Recommendation 2009/C 155/02 of the European Parliament and of the Council of 18 June 2009 on the establishment of a European Credit System for Vocational Education and Training (ECVET), 2009/C 155/02, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:155:0011:0018:EN:PDF>

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Rather than aiming to harmonise or substitute national systems it provides a *methodological framework* for describing qualifications across the EU, in this case expressed in terms of *units* of learning outcomes with associated ECVET *points*, and transferable *credit* given for assessed and documented learning outcomes. Although ECVET is concerned with *compatibility* of national qualifications systems, the Recommendation clarifies that it is **not an instrument for granting mutual recognition of vocational qualifications**.

Apart from contributing to the attractiveness of the VET sector, valuable in light of high youth unemployment and the increasing tendency amongst young people to opt for a university education, ECVET helps valorise learner mobility by making it easier for employers to understand qualifications gained abroad. It provides a level of transparency and legitimacy to foreign qualifications while simultaneously stimulating education and training periods abroad. The 2014 review and evaluation of its first implementation stage might provide further insights as to what could be adapted to CPD.

ECVET lessons for CPD

ECVET's approach could offer lessons for the health professions not least because ongoing workplace learning can play an important role for high quality care provision. Moreover, the shift in healthcare delivery, including integrated care and working in interdisciplinary teams composed of individuals with a variety of qualifications is important for the health professions.

The parallels between VET and CPD are thought-provoking given the diversity of national systems in both areas, and the many different ways in which activities can be conceived of (in the case of CPD, e.g. mandatory, voluntary, formal, informal), combined with the European-wide practice of recording CPD 'credits' or the minimum number of hours an individual has undertaken.

ECVET's focus on describing *learning outcomes* rather than simply on the content of educational and training activities (Bjørnåvold & Le Moullouir, 2009) is in line with the trend to 'broaden' CPD and measure its impact on clinical practice and patient safety. The focus on outputs has been described as a more pertinent measure of the impact of CPD (Friedman & Woodhead, 2008) and ECVET provides a template for how such measurement might be realised.

Moreover, ECVET allows for attestation and recording of learning outcomes acquired through formal, informal or non-formal learning. This is of particular interest since the first review has shown that CPD takes many different forms across Europe. In the health professions, acquisition of knowledge, skills and competences can sometimes occur almost subconsciously, e.g. as a 'by-product' of activities ranging from conversations to unplanned reading and spontaneous observations, all of which could contribute to improving professional practice. This relatively recent insight is also expressed in the 2012 Council Recommendation on the validation of non-formal and informal learning³⁵.

ECVET's voluntary character and implementation 'through partnerships and networks based on learning agreements', which take the form of Memoranda of Understanding, also encourages proactive international collaboration and reflection about credit transfers. The consultations with CPD stakeholders confirmed that international exchange of information and sharing of best practices would be welcome in CPD. For ECVET, the EC has set up a stakeholder group which has created a users' guide in order to expedite its implementation³⁶.

Continuing vocational education and training (CVET) is a key instrument in improving employment opportunities through upskilling and skills development measures. However, this appears to be primarily used at national level for (re-)inserting out-of-work or less qualified workers rather than for

³⁵ Council Recommendation of 20 December 2012 on the validation of non-formal and informal learning, 2012/C 398/01, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2012:398:0001:0005:EN:PDF>

³⁶ ECVET Kit User Guide available at <http://www.ecvet-toolkit.eu/site/userguide>

upgrading the knowledge of skilled workers³⁷. Nonetheless, given the substantial influence of workplace learning and assessment in health, and the strong impact of health systems on individual practice (e.g., different infrastructures, case-mix and organisation of care), an approach to CPD that would draw from the lessons learned from ECVET could potentially allay some of the confusion over qualifications and their equivalency.

European Quality Assurance in VET (EQAVET)

The European Quality Assurance Reference Framework for VET, established following a 2009 Recommendation by the Council of the EU³⁸, has been designed as a reference tool for Member States to exchange best practices and in order to better promote and monitor the improvement of VET systems. By focusing on improving quality management practices – by way of common criteria, descriptors and indicators – the Framework underpins the implementation of ECVET. Its declared goal is to encourage national governments, VET providers and healthcare institutions to adopt a quality assurance process for VET, which would also enhance public confidence (EQAVET, 2011:3).

EQAVET supports the implementation of this Framework through sectoral seminars organised with VET providers, policymakers and other stakeholders. In May 2011, a seminar was organised by the EQAVET network hosted by the Norwegian Association of Local and Regional Authorities in Stavanger. Participants reflected on **how quality assurance of VET is being addressed and managed within the healthcare sector** in order to support the embedding of the European Quality Assurance Reference Framework within VET systems. It also produced a policy brief on quality assurance in continuing VET in the healthcare sector, available on the EQAVET Website.³⁹ It explains the objectives of the seminars (improving/developing quality assurance in VET, reflecting on how it is addressed and managed, generating transferable policy considerations, and extracting messages for the implementation of the framework) within Europe's broader health system challenges, stating that 'up-skilling healthcare workers and the development of appropriate learning and clinical skills in future practitioners are crucial ingredients for solving some of the challenges faced by the sector' (ibid:2).

The EQAVET framework expressly focuses on *continuing* VET, linking it to LLL by emphasising that VET learning does not end with initial training. The quality descriptors and indicators correspond to the four stages of its quality cycle (planning, implementation, evaluation and review) to support documentation, development, monitoring and evaluation to improve VET quality management practices at system, provider and qualification-awarding level.

Lessons for CPD

Quality assurance is equally important in CPD and a systematic approach could be one way to stimulate more transparency and create synergies between initiatives aiming to modernise different areas of education (Scott, 2012). EQAVET includes systematic self-assessment and internal/external assessment mechanisms defined by Member States. In this way, it

³⁷ See for example the CVET information provided by the German Federal Ministry of Labour and Social Affairs, <http://www.bmas.de/EN/Our-Topics/Initial-and-Continuing-Training/support-for-continuing-vocational-education-and-training.html>

³⁸ 2009/C 155/01 Recommendation of the European Parliament and of the Council of 18 June 2009 on the establishment of a European Quality Assurance Reference Framework for Vocational Education and Training, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2009:155:0001:0010:EN:PDF>

³⁹ EQAVET Policy Brief 'the healthcare sector' (2011), http://www.eqavet.eu/Libraries/Policy_Briefings/Policy_Brief_on_the_EQAVET_sectoral_seminar_on_quality_assurance_issues_in_continuing_VET_within_the_healthcare_sector.sflb.ashx

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(...) recognises that approaches to VET need to be compatible with the national/regional system, the needs of the industry and the community (...) The framework acknowledges that diversity among VET systems and providers is desirable. The EQAVET Framework defines the prerequisites for basic QA in VET in broad terms. (EQAVET, 2011:2)

EQAVET thus fosters an 'LLL orientation' in VET, which integrates quality improvement at all levels and recognises that 'practical skills and critical judgment based on evidence and experience' are key to the education and training of all health professionals, who must also have 'ample opportunity to nurture and encourage the development of appropriate attitudes and professional conduct' (ibid.).

European Qualifications Framework for LLL (EQF)

While the idea is much older, the development of qualifications frameworks goes back to the 1980s when, amongst others, the National Vocational Qualifications (NVQ) system was introduced in the UK (Bohlinger, 2012). Since then, many EU and the EFTA countries have used such frameworks (and/or credit transfer systems) including France, Ireland, Malta and Norway (Guest, 2006). Qualifications frameworks that can serve multiple purposes but have been described as 'drivers for change since they are expected to promote accessibility and permeability between learning pathways and realising the learning outcomes orientation' (Guest, 2006.:281).

At EU level, EQF development was stimulated by a joint progress report of the Council and the EC on the implementation of the Education and Training 2010 work programme⁴⁰ which highlighted the need to develop an EU-wide qualifications framework. Its establishment is also the subject of a 2008 Recommendation by the European Parliament and Council⁴¹.

The result is an overarching common reference system for lifelong learning – including general and adult education, vocational education and training, and higher education - that links different national qualifications systems and frameworks together and functions as a translation device that helps make qualifications more readable for enabling worker and student mobility. A 2013 Commission report described it as 'a hub to which other EU policies and tools, including credit transfer and recognition, relate.'⁴²

Unlike national qualification frameworks (NQF), the EQF shares ECVET's voluntary approach; its successful implementation depends on international cooperation and mutually accepted agreement and understanding of its purpose as a framework and system (Bohlinger, 2012). Critics have viewed the gradual referencing of NQFs (involving moderate self-certification) as a potentially problematic endeavour since different countries display different requirements and taxonomies (Drexel, 2006). In recognition of this problem, the EC has established an EQF and ECVET support portal which, *inter alia*, contains 'Guidelines for ECVET and Prior Learning Assessment and Recognition (PLAR) application in VET praxis'. There are of interest because they show how EU transparency instruments (in this case, EQF, ECVET, Europass) can complement each other and how they can be linked with

⁴⁰ Joint progress report of the Council and the Commission on the implementation of the 'Education and Training 2010 work programme' 2010/C 117/01, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:117:0001:0007:EN:PDF>

⁴¹ Recommendation of the European Parliament and of the Council of 23 April 2008 on the establishment of the European Qualifications Framework for lifelong learning, 2008/C 111/01, <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=oj:c:2008:111:0001:0007:en:pdf>

⁴² Report from the Commission to the European Parliament and the Council, Evaluation of the European Qualifications Framework (EQF). COM(2013) 897 final, p.10

learning outcomes in PLAR.⁴³ These guidelines are PLAR specific but the parallels with CPD are abundant given the focus on learning outcomes (knowledge, skills and competences), which can be linked to EQF or NQF.

EQF's eight levels of learning outcomes provide a reference for ECVET. According to the EQF website⁴⁴, the different levels are meant to demonstrate

- What the learner knows;
- What the learner understands; and
- What the learner is able to do, regardless of the system under which a particular qualification was awarded

These three objectives also appear to provide a potential fit with the reflective cycle of CPD.

By illustrating *levels* of qualifications, EQF goes beyond initiatives such as Europass (see below) whose diploma and certificate supplements make reference to the appropriate EQF level. EQF is compatible with the specific qualifications framework for higher education developed under the Bologna Process (levels 6, 7 and 8 correspond to Bachelor, Master, Doctorate cycles) but some descriptors differ as EQF encompasses qualifications gained in VET and at work.

There is also an important distinction between the EQF and competence frameworks: the former enables the *classification of qualifications levels and systems* while the latter serve to classify *individual* competences. Learning outcomes under EQF are more comprehensive as they might include knowledge other than developing skills/competences but that can still be validated (Council of the EU, 2008a). They are defined in EQF as 'statements of what a learner knows, understands and is able to do on completion of a learning process' (see Küßner, 2012:48) However, there is a simultaneous trend towards defining basic key competences in education (Halász & Michel, 2011) and in LLL (Hozjan, 2009) expressing the desired outcomes of applying the various instruments.

Lessons for CPD in the health sector

EQF contains an equity dimension in the sense that the promotion of non-formal and informal learning could benefit vulnerable individuals in order to increase their participation in the labour market (Colardyn & Bjørnåvold, 2004; Bohlinger, 2012). EQF also lends itself for link-up with both mandatory and voluntary CPD systems where these are meant to meet job market based criteria.

It is also an example of a system based on trust between national, regional and sectoral level stakeholders operating within their own frameworks yet collaborating at European level, which is potentially useful for health professional CPD where it may also not be possible to fully 'harmonise' systems.

Quality assurance (see also below) remains however a difficult task that can only proceed once the equivalency of professional qualifications of health professionals has been established. The EC's evaluation of the EQF found that, while there is compatibility between EQF, EQAVET, and ESG⁴⁵ (standards and guidelines for quality assurance in the European higher education area), in all three cases they '(...) refer to quality assurance in education and training in general only, and do not provide specific guidance for ensuring the quality of the learning outcomes approach, qualifications and qualifications frameworks. The on-going evaluations (...) should be used to identify where further synergies between European qualifications frameworks and quality assurance arrangements can be

⁴³ www.euVETsupport.eu

⁴⁴ For more information on EQF, see http://ec.europa.eu/eqf/home_en.htm

⁴⁵ See http://www.engq.eu/wp-content/uploads/2013/06/ESG_3edition-2.pdf

achieved'⁴⁶. Moreover, the EC notes that synergies with the revised Directive on the Recognition of Professional Qualifications should be sought, which uses only five levels, the top two referring to higher education.

Although European countries were invited by the EC to reference their NQFs to the EQF, and the EQF portal displays the degree to which NQFs of countries that have finalised the process are linked to it⁴⁷, there are caveats when it comes to the fit with national educational and professional cultures. In VET for example, EQF implementation occurs at different speeds. It is slower in countries like Germany with regionalised, 'dual VET systems' involving well-developed apprenticeship schemes focused on the national labour market and less likely to link up with other educational sub-systems (Deissinger, Heine & Ott, 2011; Helgøy & Homme, 2013).

The suggestions brought forward in the EQF evaluation to enhance its relevance, effectiveness and impact include the following:

- Accelerate NQF referencing
- Strengthen the role and impact of qualifications frameworks based on learning outcomes at national and European level
- Make better use of EQF in policies and tools for mobility and LLL
- Strengthen the link between European quality assurance and qualifications frameworks
- Develop the EQF to make it better adapted to current developments in online learning and international qualifications

The ongoing public debate over the European Area of Skills and Qualifications may lead to a revision of the current EQF and creation of new instruments for building closer links with CPD, amplified by the referencing of the revised Directive on the Recognition of Professional Qualification's common training frameworks to EQF and the emphasis on the learning outcomes approach.

European Credit Transfer and Accumulation System (ECTS)

The ECTS, set up in 1989 for the transfer of credits in Erasmus student mobility, is one of the tools of the European Higher Education Area (EHEA) increasing transparency of higher education. It is also used for accumulating credits in institutions' degree programmes. The EC website describes its purpose as follows: 'By making higher education comparable across Europe, ECTS makes teaching and learning in higher education more transparent (...) It aids curriculum design and quality assurance and allows for the transfer of learning experiences between different institutions (...)'⁴⁸ Originally exclusively used for credit transfer, ECTS has been turned into an 'accumulation system', i.e. a higher education mobility instrument and principal part of the Bologna Process and convergence of EU higher education systems (Guest, 2006). As mentioned above, one example is that the minimum duration of basic training for the five sectoral health professions under the revised Directive on the recognition of professional qualifications may be expressed also in ECTS.

ECTS is based on workload and learning outcomes and helps in the design, description and delivery of programmes. It allows for integration of different types of learning in an LLL perspective and facilitates mobility of learners through the recognition of qualifications and periods of study. It can be applied to all programmes regardless of the mode of delivery (classroom-based, work-based, distance learning) or the status of learners (full-time, part-time), and to all kinds of learning contexts (formal, non-formal and informal).

⁴⁶ COM(2013) 897 final, p.7

⁴⁷ http://ec.europa.eu/eqf/home_en.htm

⁴⁸ http://ec.europa.eu/education/tools/ects_en.htm

The ECTS Users' Guide⁴⁹ offers guidelines for implementing the system, to students and other learners, academic and administrative staff in higher education institutions, as well as employers, education providers and any other interested party. A revised version will be adopted in 2015 by the education ministers of the European Higher Education Area to shift the focus from course duration to learning outcomes, in line with Bologna's prioritisation of student-centred learning. It remains to be seen whether it will also mention CPD.

The above mentioned study for DG MARKT (GHK, 2011) evaluated the use of ECTS credits in medical education as part of the Bologna Process. It concluded that, although awareness of ECTS was high and competent authorities regarded its use for calculating the duration of training as adding value to the recognition process, there is concern over its uneven application across Member States and lack of agreement about its fundamental role. The question remains whether it is desirable to potentially replace or complement duration expressed in hours (teaching / contact) through credits (workload linked to learning outcomes) alongside the six-year requirement for doctors (ibid.:157). Credits could potentially allow for more flexibility for learners and in programme design, but as long as they entail different things across Europe, their role is constrained.

The MEDINE2 project (see below) promoted the implementation of ECTS in lifelong learning in medicine. One of its work packages developed a toolkit to link up learning communities of students, teachers and administrative staff in European medical education networks involving personal contact, web technology and promotion material to offer information and best practice principles. The goal was to have ECTS implemented in at least 70% of medical faculties in the EU by 2012 and to increase student mobility by at least 10%. This work complements the MEDINE Thematic Network's (2004-2007) development of European specifications for learning outcomes of primary medical degrees.

ECTS lessons for CPD

As mentioned above, ECTS can be used for LLL purposes including CPD given that the latter can take place at the highest levels of the EQF. However, as mentioned above the literature does not reveal what percentage of health professional CPD is currently delivered by higher education institutions. It also remains unknown what impact the development of competence-based curricula in health professional programmes might have on future CPD content and delivery.

Following the logic of formal degree programmes, ECTS credits allocated to CPD are based on the workload needed to achieve defined learning outcomes. Credits awarded for CPD may be recognised and accumulated towards an academic qualification in some countries and for some professions, depending on the intention of the learner and/or the requirements for its award. The allocation and recording of credits, as is the purpose of ECTS, thus allows flexibility as learners who only wish to follow particular educational components can use their credits towards a future qualification provided that the learning outcomes satisfy its requirements.

However, the European experience of ECTS also illustrates the problems related to its implementation, e.g. finding equivalent measurements for credits and workloads in the different Member States⁵⁰ and its impact on national agendas (Huisman & Van der Wende, 2004).

The prerequisite for expanded ECTS use is that validation and recognition instruments deployed in formal education adapt to the emergence of a much more diversified educational offer. The fact that prior learning – which may or may not include formal CPD – is accepted and assessed in a number of Member States towards academic qualifications demonstrates the increased permeability between

⁴⁹ http://ec.europa.eu/education/tools/docs/ects-guide_en.pdf

⁵⁰ For example, see the survey of the National Unions of Students in Europe (ESIB) survey at <http://www.eua.be/eua/jsp/en/upload/ESIB%20survey%20on%20ECTS.1068808901057.pdf>

different types of education and utility of credit based, modular learning, e.g. for mid-career professionals with few formal qualifications (Shaw M & Green H, 1999)

Both ECTS and ECVET thus support learners in shaping their learning pathways via credit accumulation and are based on attaining the same number of credits, although the allocation differs between the two instruments. ECVET is also used to record and accumulate assessed learning outcomes without conversion into credit points.

ECTS appears to be more geared to formal CPD that can be converted into credits more easily than informal CPD, as its optional application for expressing course duration in the revised Directive on the Recognition of Professional Qualifications testifies. That said, more alignment of the instruments discussed above, coupled with the revised Directive and the Bologna Process might stimulate further possibilities for making them relevant to CPD in the health sector.

Europass

Europass⁵¹ comprises a portfolio of five mutually complementary documents. The purpose of these is to enable individuals to provide proof of their qualifications and skills clearly and easily in the Member States of the EU, the candidate countries and EEA/EFTA countries.⁵²

The key component is the Europass-CV, which provides a template for presenting professional careers (work experience, education, additional skills and competences) in a standard document easily understood across Europe and relatively widely used and accepted. The supplementary Europass-Mobility template can be used to record periods of transnational mobility for learning purposes, both educational and workplace-based, however this is much less known. Also its focus is principally on initial training and education and not on CPD.

Since there is at present a wide divergence in the way CPD is recorded, in theory Europass could include a standardised European-wide 'CPD template', which should nonetheless allow individuals to demonstrate differences. However, the experience in other sectors (e.g., agriculture⁵³ and hospitality⁵⁴) has shown that specific sectoral skills and qualifications passports not linked to Europass could be more appropriate. The second evaluation of Europass tools concluded that a mechanism is needed to better capture non-formal and informal learning⁵⁵.

EU projects in the context of CPD/LLL for health professionals

The EU has funded the mobility activities for learners of all ages under the 2007-2013 Lifelong Learning Programme, which continues to operate. These include Erasmus (higher education), Leonardo da Vinci (VET), Comenius (school education) and Grundtvig (adult education).

⁵¹ Decision No 2241/2004/EC of the European Parliament and of the Council of 15 December 2004 on a single Community framework for the transparency of qualifications and competences (Europass), <http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32004D2241>

⁵² Europass website, <http://europass.cedefop.europa.eu/en/about>

⁵³ AgriPass, <http://www.agripass.eu/page.aspx?uid=1206>

⁵⁴ QSP in hospitality, http://ec.europa.eu/employment_social/defis/publigrant/public/publications/143/frame;jsessionidpubligrantprod-dc=GVnqSGhDSVzH2TQgdHXtB7vhL8VMd9JZsp2n3z0SqH5bkxcNHBLy!-1733651585?publicationLanguage=en

⁵⁵ COM/2013/0899, Evaluation of the Europass initiative Second evaluation of the Decision of the European Parliament and the Council on a single Community framework for the transparency of qualifications and competences (Europass)

In January 2014⁵⁶, Erasmus+⁵⁷ has become the new integrated Union programme for education, training, youth and sport, bringing these programmes under one roof together with the Youth in Action programme and five international cooperation programmes. Its overall budget is 14.7 billion Euros.

Selected Leonardo da Vinci / Grundtvig projects

Of particular interest in the CPD context in the health sector are the Leonardo da Vinci (LdV)⁵⁸ and Grundtvig⁵⁹ programmes under the framework LLL Programme. They contain a number of actions including ECVET, Thematic Networks, and transnational cooperation projects.

LdV projects provide the most compelling examples of commitment in Europe to increased transparency of qualifications and increased mobility of learners in the health sector. In these projects the EQF's learning outcomes approach is confronted with sectoral realities, thereby initiating the groundwork for ECVET mobility. Grundtvig covers stakeholders involved in LLL and adult education at local, regional, and national levels, not only learners and teachers but also 'NGOs, enterprises, voluntary groups and research centres'⁶⁰.

Although not directly connected to CPD, the following selection of projects highlights how international cooperation on the application of EU transparency tools can contribute to facilitating mobility (see Annex 1 for more detailed project descriptions):

- **2get1care**⁶¹: This project tested the ECVET system for healthcare professions in Germany within a European partnership to make qualification components more accessible and transferable. It adapted the training curricula of four professions (occupational therapy, speech therapy, physiotherapy and geriatric care) to ECVET standards, developed a common core curriculum and a further training concept based on ECVET principles for teaching staff.
- **EUSAFE**⁶² - European Qualification for Occupational Safety and Health (OSH) professionals: This project provided a new professional qualification and training framework for OSH professionals, based on two existing, voluntary certification standards and EU instruments (EQF, ECTS, ECVET). It produced a range of standardised profiles at EQF levels 4, 5 and 6 to cover different levels of OSH qualifications and roles.
- **'Support structures for ECVET and EQF application in Europe'** (2012, Germany)⁶³: Project demonstrating how the implementation of EQF, ECVET and EQAVET requires support for integration into national VET practice by development of support structures (e.g., online portal, consultation forum, guidelines, workshops, and tutorial)
- **'Creating a common foundation in care with the ECC'** (UK, 2009-2011)⁶⁴: Project covering 17 countries created a European Care Certificate based on basic social care learning outcomes covering entry level knowledge (not competences) in 8 key areas
- **'Recognition and validation of non-formal and informal competencies in the context of National Qualification Frameworks'** (2011, Germany)⁶⁵: Mobility project linked to EQF's comparability of learning outcomes. Deals with validation of non-formal and informal learning outcomes, their translation into skills and competences, and how to measure and compare these in a scientific way.
- **'ECVET-path for LLL'** (2011)⁶⁶: This project produced a manual for creating LLL paths in order to help individuals recognise and validate learning outcomes acquired during their

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⁵⁷ More information on Erasmus+ is available at http://ec.europa.eu/programmes/erasmus-plus/index_en.htm

⁵⁸ See <http://www.adam-europe.eu/adam/homepageView.htm>

⁵⁹ See http://eacea.ec.europa.eu/lip/grundtvig/grundtvig_en.php

⁶⁰ See http://eacea.ec.europa.eu/lip/index_en.php

⁶¹ <http://www.adam-europe.eu/adam/project/view.htm?prj=7646#.UywCpKhdWSo>

⁶² <http://www.adam-europe.eu/adam/project/view.htm?prj=6842>

⁶³ <http://www.adam-europe.eu/adam/project/view.htm?prj=9832#.U8-iCUBRYXg>

⁶⁴ <http://www.adam-europe.eu/adam/project/view.htm?prj=5042#.U8-iOkBRYXg>

⁶⁵ <http://www.adam-europe.eu/adam/project/view.htm?prj=8546#.U8-iYkBRYXg>

⁶⁶ http://www.adam-europe.eu/prj/8531/project_8531_en.pdf

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lifetime. It helps individuals create portfolios, assessed to specific professional reference frameworks and validated following EQF and ECVET levels.

- **Tuning Educational Structures in Europe** (2000-2008)⁶⁷: The project defined generic health professional competences provided by university degree programmes and specific competences linked to professions, including nursing (Bagnasco et al., 2012)
- **'Competence standards of professional education and further education in the sector of geriatric care'** (Germany, 2009)⁶⁸: Project dealing with developing outcome oriented competence standards for geriatric care, in the context of East-West migration, using ECTS and EQF methodologies previously applied in the chemistry sector.
- **'Intercultural education of nurses in Europe'** (UK, 2010)⁶⁹: Adapted and integrated transcultural education model developed in a previous project, involving research on relevant competences and production of training modules available for integration in regional, national European continuing and initial VET systems.
- **SEALLL** (2005 - Grundtvig)⁷⁰: Project promoted self-evaluation as a learning process in order to improve the quality of teaching, learning and of management in LLL. The tool created in the project starts from a modular framework where 'self-evaluation as a dialogue in a multiplayer situation' is the key-concept.

In addition to the LdV and Grundtvig projects, which are more VET focused, **there are other projects focused on higher education and the use of ECTS:**

MEDINE2 (2009-2012)

Already mentioned above, the Medical Education In2 Europe (MEDINE2) Thematic Network, which continued the work of the 2004-2008 MEDINE network, was concerned with enabling EU-wide quality education and training of medical doctors at undergraduate level to ensure equity of access to quality healthcare across Europe. Funded under the Erasmus programme it examined various factors related to mobility, qualifications, and medical/biomedical research. For example, standards and content of medical education programmes are still inconsistent, and the transparency and comparability of qualifications are limited.

As part of its mobility activities, the Network developed a toolkit to facilitate use of the ECTS credit transfer system in medicine, thereby attempting to 'modernise and harmonise' medical education. Moreover, MEDINE2 promoted the Bologna Process as a tool for educational enhancement and investigating curriculum trends.

The overall goal, as cited on the website, was to 'have a significant impact on the consistency, transparency, quality, and overall standing of medical education in Europe. This will enhance the confidence of employers, patients and society in the doctors who serve them; enhance the safety, health and productivity of patients across Europe; lead to a more satisfied medical workforce; and promote equality of access to good medical care'.⁷¹

PharmaTrain

The PharmaTrain project, set up in 2009 under the Innovative Medicines Initiative (IMI), a public-private partnership, aims to create and implement a modular Masters programme in Pharmaceutical Medicine and Drug Development Sciences. The programme is based on the Bologna credit and title system and builds on the new PharmaTrain Syllabus 2010 of the European Federation of Courses in Pharmaceutical Medicine (EFCPM).

⁶⁷ <http://www.unideusto.org/tuningeu/>

⁶⁸ <http://www.adam-europe.eu/adam/project/view.htm?prj=5234#.U8-i9EBRYXg>

⁶⁹ <http://www.adam-europe.eu/adam/project/view.htm?prj=6699#.U8-jGEBRYXg>

⁷⁰ <http://www.sealll.eu/>

⁷¹ See <http://medine2.com/Public/about.html>

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The modular concept of the training programme also allows selection of courses for accredited CPD and individualised training. A number of courses will be standardised at the same quality level, and PharmaTrain will set, maintain and constantly improve the standards and quality management of the training schemes and practices for pharmaceutical professionals

According to its website⁷², by encouraging collaboration between industry, regulators and academia, and promoting e-learning, Pharma Train wants to facilitate flexibility, transferability and mobility. The idea is that uniform, high-level training in Europe will make the drug development process faster and more economical, tailored to patients' needs.

The project collaborators are 20 EFCPM university training programmes, 13 learned societies including 3 competent authorities, several partner training organizations and 15 pharmaceutical companies. Part of the activities has been the setting up of a pan-European accreditation system, as well as a CPD Platform and comprehensive quality management process.

LOTUS

An example of a project that did not focus on the adaption of European transparency tools but on creating an inter-professional CPD method, LOTUS was a multicentre learning programme for primary care professionals in four European countries (UK, BE, IT, ES) that delivered a CPD programme based on transnational consensus and common principles derived from adult learning theory (Mathers, et al., 2007). It aimed to develop and implement common learning methods for CPD for healthcare teams combining staff in medicine, nursing and administrative functions.

The programme involved various stages including methods for undertaking recruitment and learning needs assessments and describing learning outcomes. The most effective learning methods identified were either linked to clinical practice or involved interactive meetings and use of multiple educational interventions (ibid.).

Lessons for CPD - challenges of innovation transfer to the health sector

As this overview of initiatives and projects has shown, there are a number of interesting elements that could potentially be valuable to the five sectoral health professions. However, caution must be exercised because these tools were designed individually, at a specific time, in a specific context, with specific purposes in mind that did not (necessarily) take into account CPD. The development of competences, whether related to routine or specialised health professional tasks, depends largely on the healthcare settings professionals are embedded in. Hence the particularities of national healthcare systems complicate the application of a single regulatory system for CPD in Europe.

Among the projects described above, most are concerned with implementing ECVET at the level of professional further training, and/or developing the latter in accordance with ECVET and EQF principles focusing on learning outcomes. Many deal with determining appropriate job-specific competences which can then be validated against standards and aligned with EQF and NQFs.

Based on the projects identified, the application of ECVET and EQF principles appears to work in professions where day-to-day tasks entail a certain degree of repetition combined with a low degree of professional judgement. The projects also suggest that these instruments might best fit jobs and sectors where there are fewer national particularities than in health. For example, the EQF/ECVET support portal includes, alongside five other projects in the **transport and logistics sector**, the ProfDRV project⁷³, which applied the EQF approach to improve comparability and transparency of professional driver qualifications in Europe. It developed a learning outcomes based profile for road

⁷² See <http://www.pharmatrain.eu/>

⁷³ <http://www.project-profdrv.eu/>

freight transport and EQF-compatible quality standards for the implementation of related qualification structures in the Member States.

ECTS application occurs mainly in projects targeting the highly qualified, given its distinct function that is also integrated into top levels of the EQF. Academic learning is particularly widespread amongst doctors, dentists, and pharmacists, however new modes of learning and degree-level education in most countries for nurses and midwives makes 'university level CPD' attractive to all five health professions facilitated by ECTS credit transfers which make possible flexible learning.

The previously mentioned study commissioned by DG MARKT on the interaction between the Bologna Process and the Professional Qualifications Directive (GHK, 2011) noted that, while not opposed to the approach as such, 'one of the issues that medical stakeholders returned to time and again (...) was the perceived impracticability of agreeing a framework of competences and learning outcomes that could form the basis of a system of automatic recognition for doctors' (ibid.:11). Some of the reasons provided include insufficient experience with the use of learning outcomes and concerns that instruments that provide more formal recognition of learning outcomes could weaken the theoretical underpinning of medical degrees.

However, the validation of different types of knowledge, skills and competences promoted by these projects is of interest to CPD. Similarly, portfolios for recording activities play a growing role in CPD where they serve in many frameworks as self-evaluated evidence of having undertaken relevant activities and reflection.

Nonetheless, the projects suggest that formal accreditation may be difficult to achieve for certain activities in healthcare, as opposed to other sectors where workers are equally mobile⁷⁴. While there is no concrete evidence in the literature as to why exactly this might be the case, the comments received from stakeholders (see below) suggest that this could be because, regardless of the transparency and trust these tools are creating, they are not sufficient to satisfy national labour market and/or safety requirements, and regulations governing the health sector.

As debates over core competences are ongoing, both as part of the revised Directive on the Recognition of Professional Qualifications and more generally, e.g. regarding public health professionals (Birt and Foldspang, 2011), the focus of Tuning and similar projects⁷⁵ lies in expanding problem-solving competences to becoming 'systemic' competences, i.e. output-based learning that involves critical thinking and a broader understanding of health system issues and roles.

The SEALLL (Self-evaluation in adult LLL) programme shows how dialogue between staff, teachers and learners within and between institutions and external actors became the starting point for self-evaluation and reflection, both central activities of the CPD cycle.

European level initiatives in the sectoral health professions

In addition to CPD and education/training initiatives undertaken at EU level in order to encourage and steer coherence of CPD systems in Europe there are also specific initiatives initiated by actors outside the European Institutions which review CPD approaches in Europe.

Notably, the surveys conducted by health professionals' European umbrella organisations such as the European Federation of Nurses Associations (EFN, 2012) and the Union of Medical Specialists in Europe (UEMS, 2011 and 2013), and those undertaken by other stakeholders such as the General

⁷⁴ Other Leonardo da Vinci projects describe how European accreditation against EQF has been achieved for training providers of fitness instruction (United Kingdom) and for sports coaches (Sweden).

⁷⁵ See also the LdV project 'Best practice in nursing in different health institutions in Europe' (Austria, 2009)

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Medical Council in the UK (Murgatroyd, 2011) and the *DentCPD* project (2010-2012, funded by the EC) fall into this category. Elements of these were already described in the first literature review, and put together they provide some of the most insightful information available on the status quo of CPD systems currently in place in Europe in spite of the fact that they do not look across professional boundaries and do not cover all EU/EFTA countries.

In addition to activities by the five health professions covered by this study, the activities and survey results of the UEMS-EACCME® are also relevant for detecting European CPD trends.

Doctors

CPD-type activities have a very long history in medicine. Already in the Middle Ages, city officials in Florence obliged physicians to attend annual refresher meetings to remain up-to-date with scientific progress and change (Pozniak, 2007).

Today, it remains an ethical obligation for health professionals which, for many doctors, is deeply rooted in their professional philosophy. Moreover, CPD is a legal obligation for doctors in many Member States.

General Medical Council Survey

The international (covering 16 European and 11 non-European countries) survey on CPD undertaken by the UK's General Medical Council (GMC - Murgatroyd, 2011) is described, along with the *DentCPD* and EFN surveys described below, in the first literature review. In spite of its limitations in terms of scope, this report provides fairly comprehensive account of CPD systems and the way that regulatory bodies, medical societies and doctors make use of it. It is worth noting though that the terms used by the GMC may not correspond exactly to the ones agreed upon by the consortium for the purpose of this study, e.g. 'mandatory CPD' is not defined in the GMC's own glossary. This might also explain the discrepancies between the findings of the GMC and the UEMS (see below) surveys.

Looking at the survey findings in more detail, the following broad observations were brought to light:

- For physicians, CPD was found to be mandatory in 12 European countries (UK, IRL, DE, GR, HU, IT, NL, NO, PL, SK, SL) and voluntary in 4 (AU, BE, ES, SW), with a marked trend of moving away from voluntary schemes;
- Most of the regulatory bodies have developed standards and guidelines on the use of CPD, which can be rather broad or very specific;
- Most regulatory bodies set the minimum number of credits / hours doctors should gain / spend on CPD on an annual basis in order to meet requirements;
- The consequences for non-compliance of mandatory CPD vary and range in severity, and it is unclear as to whether more serious sanctions are enacted;
- Where CPD is mandatory, it is sometimes linked to financial and status benefits; in a number of countries it is linked to revalidation, re-certification and -registration
- In a few countries regulatory bodies determine the subject matter for CPD or the type of CPD that must be undertaken (e.g. formal programmes)
- Where auditing of physicians occurs, they are usually required to submit evidence of CPD activities, i.e. taking the form of portfolios
- Accreditation of CPD activities and providers is extensive and undertaken by a variety of actors, including regulatory bodies, medical chambers, medical associations, medical/professional societies, etc.; the delivery of CPD schemes is carried out by professional medical societies (e.g., specialist colleges, Royal Colleges and postgraduate organisations such as Deaneries in the UK), which also accredit events by themselves

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Monitoring and compliance of CPD remains a challenge, something that also been noted in the USA (ibid:9). The fact that the development of standards and guidelines is becoming ever more important reflects growing European concerns over quality assurance and patient safety.

Medical specialists' initiatives

The European Union of Medical Specialists (UEMS) is the largest and oldest (since 1958) medical organisation in Europe representing more than 50 medical disciplines. The UEMS website cites as its organisational objectives 'the promotion of quality patient care through the harmonisation and improvement in the quality of specialists' medical care throughout the EU, and the encouragement and facilitation of CME for European specialists.'⁷⁶ For over 20 years, UEMS has been active in the field of CME-CPD and produced a number of important documents, including the following:

- Charter on CME of Medical Specialists in the European Union (1994)
- Criteria for International Accreditation of CME (1999)
- Basel Declaration on CPD (2001)
- Declaration on Promoting Good Medical Care (2004)
- Budapest Declaration on Ensuring the Quality of Medical Care (2006)

As emphasised on the UEMS website, the primary message is that CME-CPD is a moral and ethical obligation to doctors.

Whereas national CPD is regulated by National Accreditation Authorities (NAA), in the international domain UEMS has set up the European Accreditation Council for Continuing Medical Education (EACCME®), in response to the observed shift towards mandatory CME-CPD. Since 2000, UEMS-EACCME® is concerned with the mutual recognition of accreditation of EU-wide and international CME-CPD activities for live educational events (LEEs) through the awarding of European CME credits (ECMEC) to individual medical specialists, allowing the recognition and exchange of credits between all European countries. In 2009 UEMS-EACCME® also began accrediting e-learning materials.

Through its activities, UEMS-EACCME® wishes to promote the highest quality standards. By providing European Accreditation for Live Educational Events and e-learning materials, the UEMS has implemented a double evaluation of these events or materials from a National Accreditation Authority's perspective and from a specialist-based perspective. It operates as a link between the National Accreditation Authorities, the UEMS Specialist Sections and Boards, the European Specialty Accreditation Boards and providers of CME activities. By validating and awarding the credits proposed by the boards and national authorities, its work is complementary to the competence and activities of National Accreditation Authorities.

UEMS also has mutual recognition agreements with the American Medical Association and the Royal College of Physicians and Surgeons of Canada (live events), thereby facilitating international transfers of credits. Importantly though, EACCME® credits are not recognised in all EU countries, France and Germany being notably absent. However, discussions with Germany are ongoing.

The organisation has been involved in conducting studies on CPD amongst medical specialists since 2003. Its comprehensive 2012 survey found the European CPD landscape to be mixed, with different national approaches concerning CPD obligations and the authorities responsible for CPD and validation (UEMS, 2012). The preliminary results of the latest UEMS survey, initiated in December 2013, were presented by Dr Len Harvey (UEMS Honorary President) at a 2014 UEMS conference on CME-CPD in Brussels. The survey covers the 29 EU/EEA countries plus Canada, the United States, Turkey, Armenia and Israel, thereby ranking among the most comprehensive and up-to-date in

⁷⁶ See <http://www.uems.eu/areas-of-expertise/cme-cpd>

Europe. Importantly, a number of indicative trends were reported as to where CPD appears to be headed⁷⁷, which confirm and refine the 2012 UEMS findings for the medical specialties:

- CPD was found to be mandatory in 21 countries (18 of which EU), and voluntary in 13 (all EU)
- 8 countries reported having implemented relicensing processes
- 6 countries did not report having a proper CPD cycle
- Most countries award credits per one hour of CPD activity (the average being +40 credits annually)
- 16 countries have no sanctions in place for non-compliance
- 12 countries reported having linked CPD activities to areas of practice
- CME-CPD is financed directly by doctors in 29 countries (24 EU)

In summary, CPD was found to be increasingly mandatory, credits are a key tool for fulfilling national requirements, European accreditation was confirmed to be useful, and gradual sanctions are being implemented.

In order to improve its accreditation process, new criteria for the accreditation of LEEs were introduced by UEMS-EACCME® in 2013. The 26 'essential criteria' are far-reaching and focus on learners, educational activity, independence, transparency, providers, conflict of interest disclosure and outcomes (Varetto & Costa, 2013). They apply to providers of events in the many specialist disciplines covered by various UEMS bodies including pneumology, ophthalmology, allergology, etc.

Analysing this system in the specialty of nuclear medicine, Varetto and Costa (2012:4) argue that 'UEMS-EACCME® accreditation has indeed proven to be an optimal approach allowing European doctors to move across countries thanks to the easier transfer of CME credits and enhancing the benefit gained from higher quality international CME/CPD activities'.

A number of medical specialties such as **cardiology** have signed agreements with UEMS and implemented accreditation systems in accordance with EACCME® procedures and guidelines; an example is the European Board for Accreditation in Cardiology (EBAC), one of the UEMS Specialty Accreditation Boards. EBAC reviews international activities in this discipline (events and distance-learning) and awards more points for 'higher quality' activities based on defined quality criteria (Murray, 2014). According to the EBAC website, 27 National Cardiac Societies and 2 CME Accreditation Authorities have officially recognised its competence.

Hematology is another speciality shaped by medical developments which require practitioners to keep their skills updated via CPD. Although not currently part of UEMS-EACCME®, the European Hematology Association (EHA) website⁷⁸ notes with regard to evolving CPD harmonisation that 'the international adaptation of a uniform scheme of rules and requirements, to which increasing numbers of academic and independent training institutions must comply, is an important development in Europe. Training offered by independent organizations is carefully scrutinized on a national level and by EHA for accreditation, which will be recognized internationally.'

Much emphasis is thus placed on uniform standards and quality levels to raise standards for organisations and individuals and thereby strengthen the professional status of the speciality. This is being achieved, *inter alia*, by aligning CME-CPD systems and the value of their credits. Going one step further, EHA explains that 'in the coming years this should result in a uniform European system to run alongside those of each country, allowing (...) international mobility'.

To this purpose, the EHA-CME Unit, which emerged from the previous European Council for Accreditation in Hematology, has been set up as an independent body which reviews and grants

⁷⁷ These will be discussed in more detail in a 2014 UEMS publication.

⁷⁸ EHA website, <http://www.ehaweb.org/>

accreditation to high quality educational events only, thereby allowing individuals to earn EHA-CME points. As reported at the 2013 European CME Forum, only academic or scientific organisations are eligible to apply for accreditation and only trained hematologists may represent applicant organisations (Murray, 2014). Several European countries have adopted the system. The Unit's primary objective is 'to promote the concept of LLL and to encourage haematologists to take part in peer-reviewed activities'. By linking the system to the European Haematology Curriculum, easy identification of relevant CPD events is possible.

Hematology has also been involved in Leonardo da Vinci projects including H-Net (European Network for Harmonization of training in hematology, 2008-2011). In a joint effort of 26 partners⁷⁹, H-Net aimed to create a truly harmonised curriculum for European hematologists, thus raising competence levels and improving patient care and public health.

Nurses

Like the other health professions, nurses have always engaged in CPD even if its formal organisation may have occurred later than for doctors.

EFN survey on Nursing in Europe

The European Federation of Nurses Associations (EFN) produced a 'Country Report on CPD in Nursing' (EFN, 2012), based on a survey undertaken amongst their members in the EU Member States, Norway, Switzerland, and Iceland. The report is situated in the context of the Bologna Process and the Professional Qualifications Directive and it complements a number of EFN position statements (e.g. on Working Time and on Education Policy). It also supports their work on promoting a highly skilled nursing workforce and sustainable health system reform.

As stressed by EFN, 'in the context of quality of care and patient safety in Europe, it is imperative that all nurses become active participants in the development of knowledge and practice. It is very important that the nurse has the individual responsibility to be accountable and able to lead quality improvement organisations' (ibid:1).

The report includes an Annex providing detailed descriptions of CPD in nursing for 27 countries. Its conclusions contain the following findings which, although applicable only to the nursing profession, nonetheless reveal some indications about the overall direction CPD is headed in:

- CPD in nursing was found to be mandatory in 14 Member States;
- In 12 Member States the nursing regular requires nurses to provide evidence that they are professionally up-to-date;
- There are different ways of expressing CPD in the Member States (hours, credits);
- In 11 Member States there is a legal requirement of a minimum number of study days per year to continue to practice as a nurse;
- The individual nurse, employers and governments play a role in funding CPD

Crucially, while these findings confirm that CPD plays a significant role in nursing, only 8 National Nurses Associations were satisfied with the status quo of CPD in their respective country. Moreover, the inconsistencies in expressing CPD demonstrate that the Bologna Process has not been fully implemented yet in nursing.

More importantly, the EFN findings show that 'there seems to be no evidence of better patient safety in countries with mandatory continuous education and recertification. It is very important that nurses have the individual responsibility to be accountable and be able to lead quality improvement'. This

⁷⁹ <http://www.adam-europe.eu/adam/project/view.htm?prj=4024#.U8zQVEBRYXg>

statement highlights the particular importance that self-regulated learning through various delivery modes (formal, informal, incidental) plays for nursing professionals operating in a dynamic, time- and resource-constrained and gender/diversity sensitive environment.

Other nursing considerations

While not a study on CPD as such, the findings of the RN4Cast – nurse forecasting in Europe study⁸⁰, financed under the European Union's Seventh Framework Programme (FP7), suggest that engaging in CPD is a challenge for nurses having to cope with the serious impacts of healthcare budget cuts and austerity measures, which have further amplified shortages of nurses in many countries and critically impacted on nurses' working conditions and salaries. These impacts are also described in detail in another EFN study, 'Caring in Crisis', which provides a comparative overview of 34 European countries (EFN, 2012) and, inter alia, found that:

- Over half of EFN members reported pay cuts, pay freezes and rising unemployment rates for nurses;
- Over a third reported concerns about quality of care and patient safety, and
- Over a fifth reported downgrading of nursing and substitution of nurses with unskilled workers

According to the RN4CAST team, this situation has resulted in nursing having to make tough choices by prioritising activities which, if left undone, would have immediate negative consequences on patient health and safety. Hence this occurs to the detriment of activities aiming at providing 'patient focused care' including meeting educational and psychosocial needs (Ausserhofer et al., 2014).

In addition, the results of the Irish RN4Cast study confirm that the nursing workforce is under strain, which has resulted in an environment where 'hospital training budgets and continuing professional development initiatives (CPD) seem somewhat ad hoc' (Scott et al., 2013:6). To rectify this, they propose 'Introducing a streamlined performance management and development system (PMDS) and/or Personal Development Planning (PDP) process across the organisation, in order to enable nurse managers to discuss with nursing staff their career goals and CPD needs' (ibid.). In this way, the identified training and development requirements of nurses could inform hospital service plans, action plans and wider CPD initiatives.

The EFN and RN4CAST findings are important because bad working conditions influence job satisfaction and patient outcomes, but also nursing outcomes since nurses themselves cannot evolve in a satisfactory manner. It can be extrapolated that CPD activities, especially in their formal variety, represent a luxury many nurses across Europe are unable to participate in, be it due to lack of resources, lack of time or lack of prioritisation by superiors.

Dentists

One of the aims of the *DentCPD* project⁸¹ was to identify and agree essential CPD requirements for dentists working in the EU. As part of the project, the *CPD for Graduate Dentists* questionnaire collected data from individual (143) dental educators from 30 European countries (including also FYROM, Iceland and Turkey) to seek their opinion on European CPD systems, requirements, provision and accreditation (Bullock et al., 2013). Some key findings are as follows:

- There is a notable trend towards mandatory CPD in dentistry (14 countries reported mandatory systems that are officially regulated; 8 countries had either an optional system or recommended hours; only 5 countries had no official system) and dentists were largely in favour of an official, national, accredited system (81% of respondents);

⁸⁰ <http://www.rn4cast.eu/en/index.php>

⁸¹ www.dentcpd.org

- All EU countries have a national regulatory body, and graduate dentists must register with this body before being able to practise;
- Where CPD is mandatory, certain core topics are also stipulated;
- Current requirements for graduate dentists to engage in CPD show however variation and provision is largely unregulated;
- The most common CPD providers were university dental schools and professional dental associations, and they were seen to offer the highest quality CPD by the respondent group;
- A wide range of organisations were said to be providers and accredited to award CPD points, e.g. professional associations, national regulatory bodies, state organisations;
- Knowledge of accreditation processes and criteria amongst dental educators was however mixed;
- CPD activities were most commonly funded by dentists themselves

These results led Bullock et al. to conclude that ‘the harmonisation of requirements would enhance both dentist mobility in the context of freedom of movement and the safe management of patients.’ They also pointed at the growing role of CPD within ‘systems of appraisal and recertification’ (ibid.:21).

In addition to the systematic literature review of the project which reviewed 114 related papers and studies (Barnes et al., 2012), the survey findings were considered for drawing up guidelines for the management and delivery of high quality CPD by European dental schools and other CPD providers, the focus being on transparency, quality control and patient safety.

Of interest in this context is the recommendation that ‘the mode of CPD delivery should suit the educational intentions, with clear learning objectives or outcomes’ (Suomalainen et al, 2013:29), hence echoing the trend for learning outcomes. The recommendations do not impose a particular structure but rather propose situating CPD in a multi-professional, outcome-centred framework including assessment and feedback: ‘to form comprehensive entities, the learning objectives, learning activities and assessment tasks should all be aligned (....) (ibid.:33).

Regarding the use of credits, the recommendations note that ‘credits awarded in one given country should be recognised across the European Union. This transfer can only take place if all parties involved recognise the credits and the associated learning outcomes. The content of the credit point must be clearly defined, for example, by applying the ECTS.’(ibid.:35)

With regards to accreditation, the *DentCPD* project team proposed the establishment of specific conditions for the accreditation of dental CPD activities, as is the case in the UK, where the General Dental Council (GDC) specifies what conditions must be met in order to justify that an activity may be countable as ‘verifiable CPD’ (in this case, proof of attendance, concise educational aims of the activity, clear anticipated outcomes, quality control of the activity including feedback). However, the GDC does not accredit/verify dental CPD. Moreover, both providers and educators should be quality approved and impartial.

The result of the *DentCPD* project was the publication of the *Dental CPD Reference Manual* as a supplement to the *European Journal of Dental Education*.⁸²

Another extensive literature review undertaken for the General Dental Council (Eaton et al., 2011) covering dental and other healthcare professions did not identify any studies that demonstrated benefits relating to regulatory purposes of CPD participation in terms of improved quality of care, performance, professional standards, competence, public satisfaction or safety. The literature also did not provide any information to demonstrate if CPD participation is a valid indicator of professional competence or performance although the medical literature suggested an association between

⁸² <http://onlinelibrary.wiley.com/doi/10.1111/eje.2013.17.issue-s1/issuetoc>

undertaking CPD activities and enhancing performance, e.g. through the targeted use of personal development plans and annual appraisals.

Midwives

As mentioned in the first literature review, the 'professional' function of CPD appears to be particularly strong in UK midwifery, where the Royal College of Midwives (RCM) actively supports LLL and CPD (RCM, 2013). The RCM's COIN Framework for CPD and LLL describes CPD as an applied educational tool for *consolidation* of knowledge and skills and move towards professional *ownership* and *independence*, ultimately steering midwives towards 'new ways of working' (RCM, 2003).

Building on this framework and while encompassing the traditional delivery formats like face-to-face educational events (seminars, conference, workshops) and hard copy resources, the RCM has more recently developed an online learning resource called 'ilearn'. To further support CPD and to capture reflective learning, the RCM has also produced an online portfolio called 'ifolio' which is synchronised with the ilearn, but can also be used to save evidence around any learning event. The benefit of the online resources is that users can access it from anywhere and that portfolios can follow their users throughout their careers.

While no EU-wide initiatives or projects on CPD in midwifery could be identified, the International Confederation of Midwives (ICM) has developed a set policy documents which address CPD and competencies, including ICM Global Standards for Midwifery education (2010, updated 2013) and ICM Essential Competencies for Basic Midwifery (2010, updated 2013) which underpinned the ICM Global Standards for Midwifery Regulation. In the latter, the Standard section 4.4 covers continuing competence and states the following:

4.4. Continuing competence

4.4.1. The midwifery regulatory authority implements a mechanism through which midwives regularly demonstrate their continuing competence to practise.

Midwifery competence involves lifelong learning and the demonstration of continuing competence for registration/licensure. Eligibility to continue to hold a licence to practise midwifery is dependent upon the individual midwife's ability to demonstrate continuing competence. Assessment and demonstration of continuing competence is facilitated by a recertification or relicensing policy and process that includes such things as continuing education, minimum practice requirements, competence review (assessment) and professional activities.

4.4.2. The legislation sets out separate requirements for entry to the midwifery register and/or first license and relicensing on a regular basis. A requirement for regular relicensing separates the registration/first licensing process from the subsequent application to practise process. Historically in many countries relicensing required only the payment of a fee. Internationally there is an increasing requirement for demonstration of ongoing competence (including updating knowledge) as a requirement for re-licensure of health professionals. This is achieved through the issuing of a practising certificate on a regular basis to those who meet the requirements for ongoing competence.

Already in 2003, the World Health Organization (WHO) published its 'WHO European Strategy for Continuing Education for Nurses and Midwives'⁸³, which includes fundamental guiding principles of continuing education for nurses and midwives applying to the WHO Europe Region.

⁸³ WHO (2003), Nurses and Midwives: A Force for Health', http://www.euro.who.int/_data/assets/pdf_file/0016/102238/E81549.pdf

The majority of Midwives Associations in Europe are members of the European Midwives Associations (EMA) and also of ICM.

Pharmacists

Funded under the LLL Programme, the **PHARMINE project**⁸⁴ examined the opportunities for the introduction of the principles of the Bologna declaration into pharmacy education and training with the aim of tuning the latter to the future needs in the professional disciplines of community, hospital and industrial pharmacy.

The project consortium, which included four university members of the European Association of Faculties of Pharmacy (EAFP) alongside the relevant European umbrella organisations, is developing a bachelor/master/doctorate system for pharmacy education and training taking into account the need for basic pharmaceutical competences (and mutual recognition of pharmacy qualifications) and the specialisation needed in the three main areas of pharmaceutical expertise.

Greater alignment at postsecondary education level could also have ramifications for the International assessment and comparability of CPD activities in the future.

In practice, the project partners took stock of existing EU pharmacy curricula and adapted these to the Bologna process. The goal was to create a common competency curriculum in addition to those for specialised pharmacy practice, i.e. a common pharmacy standard for higher education and training for adoption by the EU-28 Member States, candidate countries, and non-EU countries. EAFP provides advice, quality assurance and approval to countries and higher education institutions wishing to adopt this new EU standard, which is voluntary.

The **PHAR-QA** (Quality assurance in European pharmacy education and training) project⁸⁵ extends this work by focusing on the redefinition of competences in line with current trends and the adoption of a European quality assurance system in pharmacy education. It is implemented by a consortium of nine universities who will also work closely with the members of the MEDINE and TUNING projects, i.e. interprofessionally.

The **LIAT-Ph Knowledge Alliances** project, also funded by the LLL programme and using some of the undergraduate background information from PHARMINE, 'seeks to address learning needs at undergraduate and postgraduate levels, as well as addressing the continuing professional development needs of the practising industrial pharmacist'.

Other initiatives of interest to pharmacy CPD include the validation process of the 2008 Global Framework for Quality Assurance of Pharmacy Education⁸⁶, based on identified competences, by the WHO UNESCO FIP (International Pharmaceutical Federation), Pharmacy Education Taskforce which involved five EU countries.

Moreover, as noted in the first review, the development of competency frameworks has been increasingly promoted in pharmacy (Svarcaite, 2009; Royal Pharmaceutical Society, 2011). These commonly involve a compilation of essential competencies for effective practice and performance, which may or may not be tied to qualifications frameworks.

⁸⁴ Pharmine project <http://www.pharmine.org/>

⁸⁵ <http://www.pharmine.org/PHAR-QA/>

⁸⁶ <http://www.fip.org/files/fip/PharmacyEducation/Global%20Framework%20Final%20Draft.pdf>

CPD / LLL initiatives in other professions and sectors

Relevant initiatives and projects in other professions and sectors testify that CPD is not a trend or recent phenomenon but something that has engaged professionals for a long time, even if it is not a legal requirement. The following examples show how various professions and sectors are approaching CPD and what elements they are adapting, whether in response to scientific or safety needs, or to develop competence profiles based on learning outcomes to meet labour market demands.

Non-sectoral health professions

In the context of EU mobility, **hospital pharmacists** represented by the European Association of Hospital Pharmacists (EAHP) supports ‘a process for gradual harmonisation of the hospital pharmacy qualification across Europe’ to allow for better cross-border recognition of hospital pharmacists’ qualifications. Under the PHARMINE project, EAHP devised a comprehensive list of competencies necessary to improve hospital pharmacy outcomes. Moreover, a pan-European education framework is being created.

EAHP’s goals reveal the important role of CPD for the association, as they comprise the declared aim ‘to create a platform for the education and training of hospital pharmacists to a level of specialisation and maintain continuing professional development’.⁸⁷ In the absence of a pan-European pharmacy accreditation body, EAHP is accredited by the US Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education (e.g., activities at the annual EAHP congress).

Representing **industrial pharmacy**, the European Industrial Pharmacists Group (EIPG) has issued its own ‘Guidance on CPD for Qualified Persons’ (EIPG, 2007) which provides a framework for the promotion of personal commitment to CPD and links this to Article 23 of Directive 2001/83/EC, i.e. the general requirement on pharmaceutical companies who hold marketing authorizations to take account of scientific and technical progress in the manufacturing process.

The guidance proposes structured CPD programmes personalised for each Qualified Person (QP), involving a five-step CPD cycle, the core knowledge elements of which contain areas such as pharmaceutical law and administration, the role and professional duties of a QP, and quality management systems, as well as additional knowledge elements in nine areas pertaining to industrial pharmacy. Moreover, it stipulates quality assurance systems for CPD activities against learning objectives, linked to Directive 2003/94 Article 7(4) on Good Manufacturing Practice. Hence Personal Career Development Plans and evaluations are integral to the CPD system for industrial pharmacists.

In the discipline of **chiropractic**, the European Academy of Chiropractic (EAC) actively promotes CPD amongst its members to ensure quality patient care and safeguard and enhance the reputation of chiropractors in Europe. This includes a service where members can log their CPD points. In its ‘Criteria for obtaining EAC accreditation of post graduate education and CPD’ (EAC, 2011), 150 points are recommended over a five year period and minimum CPD criteria have to be met in order for members to remain in good standing and listed on the EAC website. EAC criteria pertain to CPD activities including seminars and conferences, web based learning and seminar on CD-ROM, journal reading, courses leading to postgraduate degrees, and other activities (lectures, board membership, clinical observation).

Non-health sectors

Alongside the health professions examined by this study, **architects** are part of the sectoral professions, thus benefitting from automatic recognition and CPD encouragement under the revised Directive on the Recognition of Professional Qualifications. Already in 2001, the members of the

⁸⁷ <http://www.eahp.eu/about-us>

Architects' Council of Europe (ACE) adopted a CPD Charter, committed to promoting 'systems of CPD programmes of a high and equal level in all of Europe', operational since 2010. Their Guidelines on CPD Systems (ACE, 2006) reveal this profession's stance on mandatory CPD:

(...) There is a great diversity of CPD initiatives arising out of the different national situations. A systematic approach starting from common criteria is therefore essential. This will allow for the creation of a European label that will attest the maintenance, by individual architects, of a high level of CPD. Therefore, what is needed is a voluntary commitment based on a moral and ethical approach at European level.

In the **engineering field**, a Leonardo da Vinci project (2010-2012) funded 75% by the EC allowed the sharing and diffusion of best practices gained through the *Engineers Ireland CPD Accredited Employer Standard* framework model to four other EU countries (PT, RO, SK, SL). The aim of the project was to build a network that would produce a European CPD Accreditation framework for employers of engineers, technicians and technologists. It was endorsed by FEANI (federation of professional engineers), which represents 32 European countries and encourages individual and organisational CPD. It formally adopted the *CPD Accredited Employer Standard* as an EU-wide project in 2013 proving that a relatively small-scale collaboration between a national professional association and government can be disseminated across Europe. The resulting accreditation process involves eight steps for engineering employers wishing to take part in the 'CPD journey'.⁸⁸

Unsurprisingly, there are a number of CPD initiatives for **teaching professionals**, spurred partly by 2007 Council Conclusions on improving the quality of teacher education⁸⁹ and the 2009 Conclusions on European cooperation in education and training⁹⁰, which stipulate that the quality of CPD for teaching staff should be raised. Projects such as CPDLab⁹¹, a Comenius Multilateral Project under the LLL programme, support teachers and other persons involved in CPD by delivering training courses in areas where technology and social change impact on the secondary school environment and the classroom, which require adapted knowledge and skills. This includes, e.g. courses on pedagogical use of Interactive Whiteboard technologies, improved eSafety policies, cyber bullying, social networks, responsible use of mobile ICT devices, etc.

This is also of interest for health professional CPD given the ubiquity of new technology deployed by the health workers and patients (eHealth, mHealth, monitoring equipment, etc.), the new learning approaches offered by these solutions, and the social and communication challenges they create as by-products.

In the **Information and Communication Technology (ICT) sector**, the European e-Competence Framework (e-CF) is the first sector-specific implementation of EQF. In defining 40 competences, skills and 5 proficiency levels, it provides a common language that can be understood across

⁸⁸ More information on the CPD accreditation process by Engineers Ireland is available at <http://www.cpdeurope.eu/benefits-of-cpd.html>

⁸⁹ Conclusions of the Council and of the Representatives of the Governments of the Member States, meeting within the Council, on improving the quality of teacher education, <http://register.consilium.europa.eu/doc/srv?!=EN&t=PDF&gc=true&sc=false&f=ST%2014413%202007%20INIT>

⁹⁰ Council Conclusions on a strategic framework for European cooperation in education and training ("ET 2020"), https://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/educ/107622.pdf

⁹¹ <http://cpdlab.eun.org/home>

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Europe⁹². Part of the EC strategy for e-Skills in the 21st Century⁹³ in support of digital jobs, it is a support tool for recruiting, training and assessing ICT professionals that helps identify workplace skills and competences. Its widespread adoption has started to increase the transparency, mobility and efficiency of ICT professionals across Europe.

The e-CF was developed through collaboration between experts from many different countries under the CEN Workshop on ICT Skills⁹⁴. The Leonardo da Vinci project EQF iServe⁹⁵ will take up the problem of ICT skills shortages by analysing training standards of internet-related service professions in six EU countries, providing national qualification descriptions (by learning outcomes) and relating them to the eCompetence framework and EQF. The project will also provide suggestions for improving VET quality in this sector.

An interesting application of ECVET takes place in the framework of CPD in the **nuclear sector**, mostly targeting people who have higher education qualifications, including at EQF level 8 (doctorate or equivalent)⁹⁶. A Commission Staff Working Paper (SWP) on the education and training in the nuclear energy field⁹⁷ explains that Euratom training and research programmes are designed to offer European responses to the new structure of the nuclear industry in the sense that 'one of the main goals (...) is to contribute to the sustainability of nuclear energy by generating knowledge and developing competencies' in the context of borderless mobility and LLL.' In line with other large industrial sectors (e.g., aeronautics and automotive), the nuclear sector has adopted ECVET and is aiming to use European Skills Passports.

Euratom's Sustainable Nuclear Energy Technology Platform (SNE-TP), composed of all stakeholders of nuclear fission and radiation protection (over 75 organizations), is a driving force in programmes for education and training as well as knowledge management. Training activities are mainly for research and industry workers with higher education, corresponding to EQF levels 6 to 8. According to the Commission SWP, the Euratom training strategy is based on three objectives, which generate CPD/LLL relevant questions:

(1) Analysis of the needs of industry and society with regard to training in nuclear safety culture: How can current CPD schemes be improved in view of the new structure of nuclear industry and regulation? Wherever a "European Passport" is appropriate, what kind of knowledge, skills and attitudes is needed, and what are the established standards?

(2) Convergence toward a common vision that puts the above needs in an EU perspective: Identification of new job profiles and competencies, focussing on the continuous improvement of not only safety and performance, but also sustainability, economics and proliferation resistance; Design of new training schemes in the context of borderless mobility and LLL.

(3) Development of common instruments that meet the above needs and vision: Need for definition of learning outcomes in terms of knowledge, skills and competences recognized in ECVET; identification of portfolios of learning outcomes that will allow an individual to prove his competencies in a coherent manner recognized by all employers in the EU; political support and funding sources at national and EU level.

In the **biomedical sector**, the Leonardo da Vinci project "European Professional Dossier of Continuing Development" was the first at EU level, creating a paper based dossier designed to collect all CPD activity through the working life of a BMS (biomedical laboratory scientist). The EucoLABS project (European guidelines for CPD)⁹⁸, also financed under the LLL programme, is turning this into

⁹² <http://www.ecompetences.eu/>

⁹³ E-Skills for the 21st Century, http://ec.europa.eu/enterprise/sectors/ict/e-skills/index_en.htm

⁹⁴ CEN ICT Skills Workshop, <http://www.ecompetences.eu/cen-ict-skills-workshop/>

⁹⁵ <http://groupspaces.com/eqfiserve>

⁹⁶ Cf. <http://ehron.jrc.ec.europa.eu/about-ehro-n>.

⁹⁷ Staff Working Paper accompanying COM(2011) 563 on Situation Report on Education and Training in the Nuclear Energy field in the EU, SEC/2011/1046 final <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52011SC1046:EN:NOT>

⁹⁸ http://www.biomed-austria.at/downloads/European%20guidelines%20for%20CPD_final.pdf

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an electronic dossier. According to the project website, 'A good CPD system aims to give the BMS the possibility to register his/her continuing professional development in a way that it captures all relevant information. It should be clear what kind of activities can be registered and how it can be done. It is also important to use a standardised credit system to be able to implement CPD similar in all the European countries.' (ibid).

Countries already working with a mandatory CPD programme are asked to compare the guidelines proposed in the EucoLABS project and adapt their CPD wherever possible and necessary. Countries organising CPD at an informal level can use these guidelines as a basic document for the organization of CPD at a mandatory level. An important point of discussion is the cycle that can be used for CPD, which is left to individual countries depending on their own regulations. A continuous cycle is recommended.

This project reviewed possibilities for a standardised credit system, including ECTS and ECVET. Importantly, neither of these systems was found to adequately capture the spectrum of activities that comprise CPD at a professional level; in the end a special system with CPD points was developed.

Based on the initiatives described above, it could be argued that some of these sectors, although also subject to professional mobility (e.g., IT, teaching) and national specificities, are more homogenous (in terms of the relevant skills required to do the job) than the healthcare sector. At national level, it could also be the case that more unified systems are in place that facilitate easier development of a CPD framework.

Further CPD debates and stakeholders

European accreditation

As a result of the 'scaling up' of CPD at European and national level as something desirable and encouraged in order to demonstrate professional knowledge, skills and competences, the question as to what mechanisms are appropriate for the quality assurance of CPD educational activities and their providers continues to be discussed across Europe. The revised Directive on the Recognition of Professional Qualifications does not regulate CPD, which means that different approaches are used throughout Europe (Davies, 2014). Nonetheless the survey conducted by the study consortium suggests that mutual recognition of CPD activities on a voluntary basis is quite common in Europe, suggesting a fair degree of confidence in quality assurance undertaken at national level.

The first literature review already established that accreditation is a contested notion and 'incredibly splintered affair' with different routes to accreditation and different types of organisations involved (Pozniak, 2007). The survey undertaken by the consortium in the framework of this study also revealed that it is available in most countries in the sectoral health professions, albeit to different degrees and mainly pertaining to formal CPD activities, regardless of whether CPD is mandatory or voluntary.

In broad terms, accreditation involves a quality assurance process that determines whether standards are met. This is commonly undertaken at a high level, e.g. by professional associations or bodies, government ministries, public accreditation agencies or higher education institutions. However, the criteria for successful accreditation differ between countries and professions. The survey conducted by the study consortium established that they include compliance with professional guidelines, learning outcomes, and duration of CPD activity, with national policy obligations more prominent than EU policy. For doctors, we can observe ongoing development of metrics in measuring the effectiveness of educational programmes on patient care (ibid.).

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As the first literature review explains, there is both terminological and conceptual confusion over accreditation, which can refer to individual educational activities or to provider accreditation, the latter being the norm in the USA and a few EU countries (Weisshardt, Stapff & Schaffer, 2012; Kopelow & Campbell, 2013); this is especially the case for dentists according to the consortium's survey.

In addition, a number of professional bodies which do not themselves accredit CPD programmes or providers – e.g., the UK General Dental Council - provide accreditation guidance. To illustrate, the GDC specifies what is considered 'verifiable' CPD and thus can be certified as such. A number of conditions need to be met including provision of a certificate that documents the number of CPD hours, as well as proof that activities have 'concise educational aims and objectives', 'clear anticipated outcomes' and 'quality controls', including the opportunity for learners to provide feedback.⁹⁹

Alongside accreditation, the first literature review discussed revalidation. Integration of CPD into regulatory processes such as revalidation of licences to practise, which most recently has become a statutory obligation for doctors in the UK (December 2012) following introduction in other EU countries, represents a tool that can serve several purposes at the same time. On the one hand, it can contribute to assuring the public that health professionals are 'fit to practise', and on the other it instigates a professional culture where the demonstration of CPD activities and their impact on practice is linked to relicensing or recertification.

Quality assurance at national level

In addition to the implications of different terminologies pertaining specifically to the relationships between CPD, CME, and continuing nursing / pharmacy / dental / midwifery education that were extensively discussed in the first literature review, there are important differences between educational pathways and national healthcare systems. How these in turn shape different learning styles and needs has been less explored in the literature. Hence it is difficult to determine in what way exactly national approaches are influenced by European initiatives unless, as with EQF, there is a clear mandate to link the two.

Referring to survey findings on mandatory/voluntary CPD systems for medical specialists in Europe compiled by UEMS, a study conducted in 13 EU countries on medical education pathways (Weisshardt, Stapff & Schaffer, 2012) shows that not only are there misunderstandings when it comes quality assurance concepts such as 'accreditation', 'certification', 'approval' and 'license' between countries, but differences also pertain to physicians' educational pathways, how CPD is embedded therein, CPD stakeholders' roles and responsibilities, and the underlying structures. Weisshardt & Schaffer (2013) argue that there are different implementation models for CME-CPD, physician-centric (e.g. Germany, Austria), politician-centric (e.g. Spain) and university-centric (e.g., Hungary). Another study by Weisshardt, Stapff & Schaffer (2012) concludes that:

A high-quality educational programme must not only fulfil the accreditation requirements of a specific country but must take into account how the learner is accustomed to learn, who are the relevant partners and stakeholders in the country and the providers should understand the environment where the learner practices in order to positively impact on patient care (ibid.:16)

⁹⁹ GDC advice sheet, <http://www.gdc-uk.org/Dentalprofessionals/CPD/Documents/Advice%20Sheet%201%20-%20CPD%20for%20dental%20professionals%20in%20teaching%20and%20research.pdf>

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Contract no. 2013 62 02 - Study concerning the review and mapping of continuous professional development and lifelong learning for health professionals in the EU

Other actors shaping CPD at European and International level

Debates over accreditation, quality assurance and the most suitable mechanisms to ensure a 'level playing field' for CPD in Europe also take place in a number of specialised fora and groups that provide participants and their members with the opportunity to discuss trends pertaining to the provision of CPD and its relationship with learning outcome approaches..

The **Rome Group**'s activities centre on the equivalency of international accreditation and credit systems in CME-CPD. The Rome Group Document¹⁰⁰ lays the foundation for CME-CPD harmonisation, by setting common standards for learners, organisers and providers, and accrediting organizations; it was accepted by CPD stakeholders including UEMS-EACCME®, the Royal College of Physicians, the Spanish Accreditation Council for Continuing Medical Education (SACCME), the Italian National Commission for Continuing Medical Education, the American Accreditation Council for Continuing Medical Education (ACCME), and the Bavarian Chamber of Physicians. Furthermore, it developed guidelines for commercial support and distance learning accreditation.

The meeting programme of the annual **European CME Forum**, organised since 2008 and based in London, acts as a 'reality check' for current issues on CME-CPD in Europe, albeit focusing on the medical profession. In the foreword to the 2013 edition, quality was identified as the most important concern, and issues such as planning for and measuring quality, as well as lack of guidance were key concerns.¹⁰¹ Forum topics provide an overview of current CME-CPD issues:

- Different accreditation systems
- Quality and compliance challenges
- Good practices
- Providing for the profession
- New approaches to CME (e-learning, blended learning, mobile learning)
- Relationship between industry and practitioners: transparency rules

The organisers also manage the *Journal of European CME* which highlights practical issues. A recent article discussed the relative benefits of accrediting provider institutions and organisations rather than CPD activities (Kopelow & Campbell, 2013). An internet survey conducted amongst European CME Forum participants found that Europeans preferred a hybrid model in contrast to the US preference for provider accreditation (Stevenson, 2013).

In response to the growing cross-border interest in revalidation, also as part of CPD systems, the UK General Medical Council in collaboration with the Federation of State Medical Boards of the United States and the UK Health Foundation co-hosted an **International Revalidation Symposium** in 2010¹⁰². The aim was to increase understanding and build the evidence base for developing systems of competence assurance for doctors in practice. Its sessions covered the following areas:

- Regulation and patient safety
- International models and approaches to licensing and revalidation
- Evaluating the evidence base
- The challenges of implementation

The Association for Dental Education in Europe (ADEE) provides a forum for educators, trainees and students across the EU and beyond to develop a global perspective on dental educational

¹⁰⁰ Rome Group document, <http://www.rome-group.org/content/consensus-documents>

¹⁰¹ See www.europeanCMEforum.eu, programme of 6th Annual Meeting, p.3

¹⁰² GMC information re: International Revalidation Symposium, <http://www.gmc-uk.org/about/10500.asp>

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issues¹⁰³. It provides a facility for external validation of undergraduate training programmes which has been taken up by dental schools across Europe, the Middle East and Asia. At the annual conference a variety of Special Interest Groups (SIG) meet. One of these is the Lifelong Learning SIG which was stimulated prior to the commencement of the *DentCPD* project and is now in its 4th year. The sustainability of the project has been maintained through this SIG, and the 2013 conference moved forward the debate to quality assurance and accreditation of dental CPD. In addition it is hoped that this continuing work will link in with a project aimed at developing a QA framework for dental CPD which is being driven through the UK Committee of Postgraduate Deans and Directors (COPDEND). ADEE continues to host and update the *DentCPD* projects' website.

The role of the **Association for Medical Education in Europe (AMEE)**, a global organisation composed of educators, assessors, healthcare students and trainees, is to promote international excellence across the continuum of education¹⁰⁴. It supports teachers and institutions in developing new approaches to curriculum, learning methods, and assessment techniques in response to changes in patient demands and educational techniques. In doing so, it is also active in 'influencing the continuing development of healthcare professions education through collaboration with relevant national, regional and international bodies' and offers courses for people involved in planning, organising or implementing health CPD.

Professional Codes of Conduct

Accreditation and compliance requirements for health professional education, including CPD, are increasingly complex. Internationally accredited CPD events are often subject to criteria and codes of conduct devised by various stakeholders including UEMS-EACCME®, ACCME, the European Federation of Pharmaceutical Industries and Associations (EFPIA) and other organisations, depending on their scope, audience, and delivery mode. As European CPD bodies are working closer together, the pharmaceutical and other commercial actors providing funding for CPD activities (the consortium survey found this to be the case especially for doctors and pharmacists) are increasingly requested to align their supporting activities with common CPD and LLL values.

The following codes of conduct and guidelines demonstrate that the provision and sponsorship of CPD is a particularly important issue when it comes to quality assurance even though the scope of these documents commonly relates to the entire scope of interaction between industry and professionals.

Launched at the 2009 European CME Forum, the aim of the **Good CME Practice Group (gCMEp)** is to look at how the European education provider/agency community works in CME-CPD and to develop the appropriate operating standards. It wishes to champion best practices, enhance standards, provide mentoring and education and work collaboratively with relevant stakeholders. Its *Core principles in current medical research and opinion* (Farrow et al. 2012) were devised with a view to adoption by European providers and other organisations involved in CME programme provision:

1. **Appropriate education:** Educational activities have clear learning objectives derived from a coherent and objective process that has identified performance gaps and unmet educational needs. Education must be designed to positively reinforce existing good practice and effect a sustained change in daily clinical practice as appropriate.
2. **Balance:** Needs to be evident in content, faculty and review. Content has to be developed independently of the sponsor and reflect the full clinical picture within the framework of the learning objectives.
3. **Transparency:** All relevant information should be disclosed to the learner so that they understand fully how the content has been developed and presented. This includes the terms of the financial support, relevant disclosures of faculty and organisations involved in the development of the scientific content and the presentation of the programme.

¹⁰³ <http://www.adee.org/>

¹⁰⁴ <http://www.amee.org/home>

4. **Effectiveness:** Post-activity evaluation should measure satisfaction, knowledge uptake and intent to maintain or change behaviour in line with learning objectives.

gCMEp is developing a toolkit to help providers understand the many rules involved in developing and presenting accredited events.

The members of the **European Federation of Pharmaceutical Industries and Federations (EFPIA)** are bound by codes of practice that govern their relationships with the healthcare professional community, payers, regulators, patient groups and governments. EFPIA describes its collaboration with physicians as ‘an example of crucial interaction during the innovation process’ and its trust building activities with health professionals and patients include involvement in the Innovative Medicines Initiative (IMI), a public-private partnership between the EC and EFPIA. Other activities involve transparency and corporate social responsibility in support of the values enshrined in EFPIA’s codes. The e4ethics platform provides information about educational events to ensure that pharmaceutical companies conduct promotion and interactions with prescribers without conflicts of interest, in compliance with applicable laws and EFPIA’s code governing relationships with healthcare professionals (EFPIA, 2013a). The ‘Disclosure Code on Transfers of Value to Health Care Practitioners and Organisations’ (EFPIA, 2013b) requires members to document and disclose the names of professionals and associations receiving payments or other transfers of value, including the amounts and types (e.g., consultancy, travel or congress fees).

The importance of CPD has also been recognised by the **European Alliance for Personalised Medicine (EAPM)**¹⁰⁵. Given the increasingly multidisciplinary practice environment, EAPM recognises the training needs of other disciplines involved in developing personalised medicine (e.g., bio-informatics, statistics) and advocates for a collaborate approach between employers, professional organisations, certification entities, regulatory agencies, and other actors. Education at all levels should produce ‘competent interdisciplinary professionals’. The mechanisms foreseen include the following:

- Education and training activities based on the curricula of diverse professions;
- Integration of elements of core competencies highlighted by research into interprofessional collaborative practice;
- Promotion of shared understanding and collaborative development of the tools for personalised medicine;
- Transparent education, transferable between countries and professions, using e-learning and blended learning, and overcoming language barriers;
- Provision of evidence-based practice for the benefit of patients and public, use of results from research for documented results of patient treatment and care

The European medical technology industry represented by **Eucomed** developed a Code of Ethical Business Practice¹⁰⁶ featuring a number of guidelines to ensure its members’ interaction with healthcare professionals are in conformity with ethical and professional standards across Europe, without replacing any national laws or regulations. Eucomed also introduced a conference pre-vetting system to review and approve third-party educational conferences and congresses in accordance with the ethical rules of the Code. The system is mandatory for members who must comply with the conference appraisal assessments.

COCIR, the European voice of the Radiological, Electromedical and Healthcare IT Industry, developed a Code of Conduct (COCIR, 2009) applicable to its members when interacting with healthcare professionals. It is trust-based (no vetting system) and includes the following fundamental principles:

¹⁰⁵ EAPM website, <http://euapm.eu/>

¹⁰⁶ http://www.eucomed.org/uploads/Modules/Publications/110504_eucomedceb_broch_210x297mm_v20_pbp.pdf

- The Separation Principle: A clear separation should exist between any advantages or benefits granted by Members to Healthcare Professionals and the decision making process resulting in the procurement of Members' products or services. The purpose of this principle is to ensure that such advantages or benefits do not influence business transactions between Members and Healthcare Professionals.
- The Transparency Principle: Advantages or benefits to Healthcare Professionals should be disclosed to their institution's administration or management.
- The Proportionality Principle: Any consideration given to a Healthcare Professional in exchange for a service or other performance should not exceed normal market value.
- The Documentation Principle: The granting of any advantages or benefits to Healthcare Professionals by Members should be document

Regarding sponsorship, COCIR members may support conferences organised by third parties and provide financial grants to organisers to cover costs (e.g. venue hire, catering) under the condition that (a) the conference is primarily dedicated to promoting objective scientific and educational activities; (b) the organiser is responsible for and controls the selection of program content, faculty, educational methods, and materials; and (c), conference support is clearly stated in advance of and at the meeting. COCIR members may also make grants for reasonable honoraria of healthcare professionals who are conference faculty members.

European perspectives on CPD

Given the limitations and gaps of the CPD literature, a number of consultations were conducted with European stakeholders to identify gaps. Some of these aspects were also discussed at a workshop for CPD experts organised on 20 June in Brussels.

The European Commission perspective

According to information provided by a representative of the **Directorate-General for Education and Culture (DG EAC)**, the nuclear project described above, as well as ECVET projects in other sectors (e.g., transport and logistics¹⁰⁷, VET mobility projects), are revealing in the sense that they suggest increased sector-based development of tools and adaptation of existing EU tools. Recording learning outcomes creates transparency as knowledge, skills and competences provide a good insight into what individuals are able to do in addition to their qualifications. ECVET in particular supports flexible learning pathways, enabling individuals with different educational backgrounds to demonstrate and validate learning activities.

Another respondent of DG EAC explained the EQF's utility as a non-regulatory comparison tool that is gradually being embraced across EU-28 and beyond. By July 2014, 22 countries had already related their NQFs to EQF, and it is expected that all 36 participating countries will do so by mid-2015. The validation of non-formal or informal training - which could include CPD - still occurs much less than that of formal educational qualifications. However, some countries include qualifications received from companies or NGOs.

The EQF demands that any new knowledge, skills and competences acquired are visible and demonstrable, including documentation, which strengthened the learning outcomes approach as it included assessment and quality assurance. This is key for creating trust amongst employers, and for raising self-esteem and motivation for future learning. 'Integrating' CPD into the EQF would involve first of all relating the relevant activities to NQF – defined by the educational structure of a given country - before linking it to the EQF. The missing link is often the ability to assess learning outcomes

¹⁰⁷ An overview of ECVET and EQF projects in the area of transport and logistics is available at http://www.project-euvetsupport.eu/fileadmin/user_upload/Downloads_front/euVETsupport_WP2_guideline_PLAR_layout.pdf, p.18

and there may be a need to provide such services in the future. Both DG EAC respondents underlined the strictly voluntary nature of the available mobility instruments.

A representative of the **Directorate-General for the Internal Market (DG MARKT)** focused on the most salient provisions on CPD for health professionals in the context of the revised Directive on the Recognition of Professional Qualifications, notably recital 15 and Articles 22 and 56 which 'encourage' health professionals to keep their knowledge current and requires Member States to report to the Commission on their undertakings in order to promote CPD. DG MARKT had worked closely with DG SANCO on the modernisation of the Directive.

One of the key points made was that the group of national coordinators - composed of representatives of ministries of education, business, and, depending on the issues discussed, also health ministries (with alternate members from several countries) - responsible for horizontal issues in the implementation of the Directive, now also includes discussion and best practice sharing on CPD as part of its function. CPD will be discussed at their meeting at the end of December 2014 / early 2015. The obligation to report CPD activities will also be discussed since it is an important transparency responsibility. The first Member States reports are expected in January 2016 coinciding with the transposition deadline, and the Commission will also be notified in case of changes to national CPD systems.

Annex 5 of the Directive, which lists the exact national titles of the qualifications enjoying automatic recognition, also specifies the minimum training requirements and/or subjects for the profession together with the relevant articles of the Directive (e.g. for doctors the training requirements are spelled out only in the articles, while for nurses the articles and the annex cover different minimum training requirements).

Also of interest is that the Directive does not exclude the possibility of eLearning and part-time study, realising that learning occurs increasingly in flexible and personalised ways.

The common training frameworks, which will be used to implement common training principles (recital 25) were described as outcome-focused in the sense that they are based on a 'common set of knowledge, skills and competences' or 'common training tests', and designed in line with the EQF (Article 49a). This marks a shift towards competence-based curricula, noticeable throughout the Directive (see also Davies, 2014). They also underline the importance of patient safety. The group of coordinators is discussing their practical implementation and content.

It was also noted that DG MARKT approaches LLL slightly differently from DG EAC. This was illustrated in the context of the general system for health professions not benefiting from automatic recognition (e.g., physiotherapists) and which subjects professionals to case-by-case decisions for obtaining recognition of their qualifications. In this regime, LLL and CPD play an important role for validation in the home Member State since all proven and documented activities can be taken into account.

UEMS

A UEMS representative reiterated the strategic role of the organisation in building trust between national authorities, avoiding duplication of work for them and in asserting the quality of CPD events through the EU-wide EACCME® system. The latter is based on bilateral agreements with countries and practically it involves standards and criteria used by reviewers in the various specialist sections.

The European Speciality Accreditation Board includes a wider pool of experts coming from scientific societies. Some specialisations such as hematology and vascular surgery have their own systems in place which work at the level of national societies but some are moving closer to the EACCME® system.

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It was underlined that European-wide accreditation is a major achievement; in the United States, there are still big differences between different States. Moreover, the system has been built for the benefit of doctors and mobility in Europe. EACCME® clearly demonstrated the value of a system that brings all countries together for the advantage of the profession as European standards had become a global reference. It was also highlighted that the EACCME® system is not designed to create additional burden or to 'coerce' countries into adopting it. But while CPD needs to take place at national and institutional level to ensure that training is fit for the domestic healthcare environment, this does not preclude facilitating accreditation at European level. The benefits include, *inter alia*, the provision of accessible state-of-the-art knowledge to all doctors, and creating pressure to improve local teaching environments. Moreover, in certain specialties such as eye surgery, the respective European congress is a facilitator since some Member States neither have the capacity nor the necessary equipment to offer CPD.

In terms of how CME-CPD is developing, the central role of continuing practice improvement and the need for evidence on CPD's impact was underlined. Hence it needed to broaden its scope, be subject to the best possible quality assurance mechanism, and encompass activities such as peer review. From the perspective of UEMS, while multidisciplinary learning is important, some activities such as team discussions do however not have the same value for all professionals, e.g. the benefits differed between doctors and other healthcare professions as for doctors there was a specific need to assess CPD's value in terms of its impact on daily practice. UEMS welcomes the UK revalidation scheme which works in interaction with EACCME®.

Regarding concerns over industry involvement, UEMS feels that CME-CPD should not become a business for medical education and pharmaceutical companies to enhance their corporate image. There should be a clear division between scientific programmes and marketing, and no private money should be involved. Regarding eLearning, given that legislation trailed technological progress it is crucial that learning modules meet the same objectives as other activities, e.g. they must provide scientifically valid, state-of-the-art knowledge worthy of accreditation.

Making reference to EU transparency initiatives, UEMS was already involved in transfer of innovation prior to the creation of ECVET in a project that developed the ECMEC credits used by the UEMS. Overall it was important to determine how to integrate components of competences into the whole spectrum of professional careers. e-Portfolios could be useful tools in this regard in order to track all knowledge, skills and competences acquired during professional careers.

From the UEMS perspective, two important CPD trends are the greater *implementation* of mandatory systems (including in countries where they already exist by legislation, e.g. France and Germany) and the continued battle for *transparency*.

Provider perspective

The programme director of the **European CME Forum** explained that it was set up as a platform for all stakeholders – accreditors, medical societies, providers, industry and professionals – to come together and share their ideas and concerns related to common standards, practices and expectations. At the same time, the Forum aims to set a challenge for stakeholders to actively drive forward CME by publishing scientific articles in the Journal of European CME. It had actively progressed European discussions over CME-CPD since there is now a cross-sectoral understanding of terms such as needs assessment despite the ongoing existence of different vocabularies.

One of the key points raised is the pressing need for stronger leadership in Europe, which may imply a bigger role for the European Commission. It was argued that, if Europe does not come up with guidelines and standards for CPD providers, the United States would do so. Already it could be advantageous for providers to seek accreditation under the US system, which is answerable to the

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Federal Government and includes strong sanctions for non-compliance with requirements. In contrast, European systems struggle to demonstrate sufficient independence.

It was reported that the Good CME Group had emerged out of discussions at the CME Forum and, in the absence of materials by external parties, their Guidelines are currently being expanded¹⁰⁸ to encompass issues related to, e.g. needs assessment and educational outcomes. Only very few other actors, e.g. the European Board for Accreditation in Cardiology (EBAC) are developing guidelines and working on practice-based learning.

In the United States, patient safety is better integrated into CPD since certain states are able to determine priorities. There may be a potential role for the EC to help define what activities CPD should encompass since providers would be happy to create content based on guidelines. Pozniak also noted that, while professional bodies are important stakeholders, accrediting activities is not their core activity and hence from this perspective he would like to see less reliance on them. Strong leadership and a quality European 'CPD badge' could serve to unify the different health professions and overcome protectionism.

Academic perspective

In particular, the input received from Professor Janet Grant (Centre for Medical Education in Context) and Associate Professor Thomas Zilling (AEMH), author and collaborator, respectively, in writing 'The Good CPD Guide' (2011) and long-time CPD researchers in the UK, Sweden and globally contains a number of issues for consideration when it comes to EU-level work on CPD:

- Of prior importance is the definition of CPD. There are two aspects:
 - The stage of CPD begins after postgraduate education has been completed, and it comprises all the formal and informal activities in which healthcare personnel takes part in order to update their knowledge or to develop their professional role
 - CPD stands for 'continuing' professional development, not 'continuous' professional development. This use of words is important since 'continuous' implies constant and non-stop, whereas 'continuing' simply implies from a given point onward, or ongoing. So continuing is the correct English terms to use.
- It is important to reconcile political and professional CPD agendas: they warned about 'overregulation' at EU level given the complexity involved in the different professional practices and identifications, different health systems, and different educational systems across Europe
- Learning approaches differ between individuals, professions and countries, which has an impact at every educational level; approaches to the profession itself and understandings of 'knowledge' are also diverse
- CPD is not a guarantee for patient safety given the different national contexts in which it is situated; what patients do when they go home cannot be controlled
- Even though CPD as a process should increase patient safety, it is important to bear in mind that CPD is not a tool to detect 'poorly performing' or insufficient healthcare personnel
- According to Professor Grant, 'managed' CPD works well if based on an appraisal system that focuses on the *process* of identifying what is to be learned, planning how to learn it, undertaking that learning and then following that up in practice
- The system of collection of credits should therefore be based on this four-step process rather than on the collection of records of attendance at CPD events which might have little bearing on need or practice
- It could be helpful if the EU provided guidance on CPD at national level, taking into account the national particularities, ensuring professional relevance, and basing it on practice

Underpinning this model of managed CPD is the evidence that there is no 'best way' to learn. This would suggest that focusing on CPD providers might be of limited value, it being that providers cannot

¹⁰⁸ A second publication is earmarked for publication in December 2014.

respond to individual needs. However, such providers could offer CPD that is required at national level to support a changing healthcare service.

Regarding CPD as a tool for enhancing mobility, Professor Grant felt that, while engaging in CPD is always positive and revealing about both individuals and their professions, CPD content is primarily geared to and relevant in the local and national professional context - it is not simply a question of recording CPD activities and thereby proving cross-border 'fitness to practice'. Instead, it may be more suitable to engage migrating health professionals in this appraisal-based CPD as part of their adaptation in host country health systems. It was also noted that ECVET and other transparency tools, which were developed in different contexts for different purposes, may not be transferable to CPD.

CPD barriers mentioned included Europe's reluctance to change from the 'credit for hours of attendance' system, as well as lack of a more global vision, which could enable providers to develop targeted activities in response to public health problems, e.g. antimicrobial resistance or smoking cessation. In Australia, CPD could be part of three-year programmes that track population health and measure education outcomes. However, the many jeopardising intervening variables that bear on patient outcomes mean that showing a direct effect of education cannot be done in other than specific and limited circumstances. It would be better simply to support the process of managed CPD based on local, and perhaps national, needs.

NHS Europe

The NHS European Office confirmed their support for the revalidation of doctors' licences to practise and stated that it would be preferable if CPD became mandatory for the sectoral health professions in Europe since merely encouraging it may not be enough. However, the process should not be burdensome for individuals and health systems. Cost and lack of time are factors that could hinder professionals from taking part in CPD, e.g. parents of young children.

Linking CPD to annual appraisals is a good way of making it an integral and ongoing part of professional careers, and linking salary scales to competences could contribute to increasing commitment to CPD. Since medical revalidation involves sign-off by someone from the same profession who has some knowledge of the individual's practice, it should be a fair process: both parties should be in a position to make the other aware of potential problems.

The importance of CPD for mobile health professionals who frequently changed jobs or returned to their professions following employment in other sectors was also underscored. CPD could be an instrument to tackle the problems of geographical flexibility and professional discontinuity.

With regard to informal knowledge, it was felt that it could be difficult to provide satisfactory evidence of CPD in some cases, especially for health professionals working without professional supervision, e.g. nurses working in private sector homes or employed by local government and based at schools.

For the NHS European Office it remains disconcerting that individuals belonging to the sectoral health professions can benefit from automatic recognition of their qualifications under the revised Directive on the Recognition of Professional Qualifications even if they have not practised for a long time and not kept their practice up-to-date by engaging in CPD. While most employers refrain from hiring such individuals and seek reassurance that continuous learning has taken place, some individuals (for example, locums placed by recruitment agencies) may not always be required to provide robust proof. Also the integration and induction of health professionals into another Member State's health system was not always easy even if individuals display technical competence, as cultural norms and local procedures and protocols vary widely. Moreover, doctors' behaviours differ between countries when dealing with patient queries and communicating health problems, as the culture is still 'top down' in

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many countries. Hence the NHS European Office stated it is particularly valuable to learn how CPD is organised across a range of European countries.

European Hospital and Healthcare Federation (HOPE)

From the perspective of HOPE, which advocates for efficiency, effectiveness and humanity in the organisation and operation of hospital services, CPD should be a tool available to all health professionals working at the hospital to encourage learning and working as a team. A number of issues were brought forward by HOPE, which illustrate the importance of CPD:

- At hospitals change occurs all the time; CPD starts right at the end of one's studies
- CPD is important for reinserting returning healthcare professionals into hospitals
- In the current crisis, professionals are staying longer in their jobs as it is safer not to be too mobile
- Patient safety does not appear in the curriculum in most countries; there are important communication aspects related to it

Reference was made to hematology where projects (e.g., eHematimage¹⁰⁹) aimed at including everybody in CPD, especially given the importance of other professions, such as lab assistants, in this specialty. Moreover, regarding the communication aspect of patient safety and importance of efficient exchanges between patients and healthcare professionals, CPD lectures on the use of colloquial English in UK hospitals are an example of targeted use. Other important CPD topics cited by HOPE are nutrition/malnutrition, mental health, the development of specific skills, and the fact that at hospital level, healthcare professionals must be able to make quick judgments in emergency situations requiring them to have the skills to perform in high pressure environments.

For HOPE, the prevailing CPD methods are not right: rather than benefitting only individuals or professions, they should encourage as well inter-professional collaboration and learning, e.g. by investigating real-life cases as done in Denmark with patient safety. CPD should also not be regarded as a tool that can solve everything since certain basics need to be taught prior to it.

While it would not work to impose CPD at European level, further EU coordination can serve to raise awareness, including also about the consequences of not undertaking it. Another discussion should focus on industry financing and the lack of quality of CPD that is not learning outcome or practice-focused.

The increasing cross-border nature of healthcare was also discussed. While mutual recognition of qualifications was created between only six countries, now it is more difficult to trust this mechanism with 28 Member States. Hence CPD, whether mandatory or not, could play a part in establishing more confidence in individuals' abilities. Transparency provides a better ability to judge whether or not somebody represents a good fit.

Social dialogue in the hospital sector

In a number of European countries such as Germany, the social partners play a decisive role in determining the development of professional training, LLL and CPD.

At European level, the **European Federation of Public Service Unions (EPSU)** is working on CPD-related issues *inter alia* in the context of the 'Sectoral Social Dialogue Committee for the Hospital Sector' (SSDC HS). An EPSU representative confirmed that the main focus of this work is on barriers to health professionals' participation in CPD activities – mainly their cost and the frequent expectation by employers to allocated free time instead of being allowed to use working time – and on improving

¹⁰⁹ <http://www.e-hematimage.eu/>

access to LLL/CPD for all health workers and how this could be anchored in collective agreements, labour law, and enterprise-based agreements. From their perspective, the following questions were highlighted as being of vital concern:

- What is the employer's responsibility for informing about, giving adequately financial support and making appropriate working time available for LLL/CPD for all workers? Staff shortages, in particular in view of nurses, healthcare assistants and workers in elderly care present additional challenges when it comes to access to LLL/CPD.
- How are CPD activities recognised? Will employees benefit from having done CPD activities (e.g., better salaries, opportunities for promotion)?
- Are there appropriate career opportunities and positions available for CPD-trained employees in resource-constrained labour markets?
- Do CPD activities offer an appropriate 'professional fit' and allow health workers to comply with requirements such as re-registration? How can CPD activities be better recognised in other EU Member States, given the already strongly Europeanised labour market for health workers on the one hand, but also persistent specificities of health systems and with regard to the education and training requirements of the different health professions, as well as skills mixes and tasks shifts?

It was emphasised that it would be seen as an unconstructive development by the social partners should CPD activities only respond to the needs of employers, for instance if the latter were to define the nature of 'useful' CPD activities. This could have a negative impact on *personal* development and filling perceived individual knowledge gaps. The fact that different types of professionals have different LLL/CPD requirements was also emphasised, e.g. the sectoral health professions tend to be more highly educated and to have easier access to LLL/CPD than other health professions whose CPD needs might be less academically oriented.

The need for more effective participation by health employers was emphasised by the Secretary General of HOSPEEM (also manager of the Dutch Association of Hospitals). He stated that, although professional organisations had an important role to play in defining CPD content, they were not in a position to claim ownership of all aspects of CPD independently since in the end, hospital managers and other health employers had to foot the bill. Hence they should have an important say in defining the type of CPD that could improve quality of care and patient safety. He argued that it is crucial to ensure that the organisational system includes checks and balances in order for it to work properly. Therefore, CPD systems should not be closed and inward-looking but must be transparent and agreed by all relevant stakeholders. He stated it was difficult to assess quality if information was held by professional groups only.

In addition, he stated that ECTS and EQF had been put into place based on a sense of urgency by national employers that they were needed. Especially in the area of CPD, it will be important not to apply a top-down approach. It is important that any initiatives trying to align CPD in a cross-border context receive sufficient support at national level from different stakeholders (ministries, employers, professional organisations, and at grassroots level). Recent discussions over the introduction of common training frameworks have shown that differences between countries can be so large that European initiatives risk causing problems.

The economic aspect of CPD was also emphasised as CPD could be used as a tool for improving sustainability and employability. In the Netherlands, the Quality Impulse initiative, which is still in its planning and preparatory phase, will provide 1,25% of the total annual budget for staffing for additional training of health professionals, which could make a difference in using CPD for ensuring better quality care.

The growing task alignment between different types of health professionals was also discussed. A number of new health professions are currently being introduced and there is a shift from hospital care

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to 'generalist' care, in the sense that groups of health professionals are working together. This required new skills that could be met through CPD. HOSPEEM itself introduced a new internal Working Group on CPD and Lifelong Learning in 2014, and it also works on the issue in collaboration with EPSU as part of their joint Work Plan.

Another interesting point was raised by a former representative of **German trade union ver.di** (*Vereinte Dienstleistungsgewerkschaft*) involved in a Working Group tasked with adapting the EQF to the German national context. Although this has been achieved, a number of weaknesses were pointed out relating to the differences between the EU focus on general knowledge and attainment of formal qualifications such as degrees (as a basis for a higher categorisation in EQF) versus the German focus on gaining practical and professional knowledge. For example, it was stated that it makes little sense that a junior doctor with formal postgraduate qualifications would be classified higher in EQF than an experienced head doctor who may not have attained high formal qualifications in the past but whose knowledge and professional skills are derived from experiences gained over several decades. Moreover, all German 'dual system' professions, including care assistant, are classified at the same level following the EQF model, which in reality does not make sense given the big qualitative differences between professions in the apprenticeship system. CPD should be a right for health professionals given that many are not self-employed and depend on their employers for accessing relevant information and setting aside appropriate time.

Finally, a policy expert at the **European Trade Union Confederation (ETUC)** with expertise of EQAVET, and of the **European Trade Union Committee for Education (ETUCE)** with expertise of CPD in the teaching sector confirmed the overarching CPD priorities of the social partners outlined above. In addition, the potential value of extending automatic recognition to CPD activities was highlighted since the revised Directive on the Recognition of Professional Qualifications is only concerned with the titles and minimum requirements of initial qualifications. Hence, CPD is a particularly important element which requires European coordination regarding quality assurance and credit transfer. CPD could be split into two categories: where it is part of higher education the ESG should provide the relevant framework¹¹⁰ and where it occurs at VET level the EQAVET tool would be appropriate. Where CPD falls into adult learning and is provided by private institutes, the latter should be completely independent and choose amongst the two streams. The importance of involving the social partners in the process was underscored.

It was suggested that there should be a common approach to quality assessment of CPD which needed to be practical. Ideally it would be linked to national systems as well as to a European level quality assessment framework, which would facilitate cross-border recognition of qualifications. For example, sectoral qualifications frameworks on CPD and EQAVET/NQAVET and EQF/NQF labels on certificates could create more trust and demonstrate excellence.

Regarding credit transfer, ECVET focuses on transfer of initial training credits only, and it is used as a credit transfer system only in some countries, which means that CPD does not come into play. However, the focus of EQAVET is changing and whereas it had originally been exclusively on initial education, this is now being expanded to encompass apprenticeships and other forms of work-based learning, which could include CPD. The drawback is that the existence of different educational pathways to a profession in different Member States (e.g. in nursing, higher education vs. VET) complicates the added value of applying also the EQF.

From the trade unions' perspective there are problems with eLearning due to quality assurance and its inability to adequately capture practical issues which require teaching in person. Concerns have been raised regarding so-called MOOCs (Massive Open Online Courses), also offered as part of Open

¹¹⁰ ENQA report on Standards and Guidelines for Quality Assurance in the European Higher Education Area (2009), http://www.engq.eu/wp-content/uploads/2013/06/ESG_3edition-2.pdf
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Education Europe, since few students actually complete the courses and there is a lack of supervision by teaching staff and of quality assurance that is decreasing learner motivation. A recent report by McKinsey¹¹¹ also noted that online learning does not lend itself well to high quality apprenticeships involving intensive practical or work-based training. Moreover, eLearning should not become a vehicle for educational advertising.

The findings of a 2012 mini-survey conducted by the ETUCE on the impact of the economic crisis on teacher education¹¹² reported consequences for CPD in terms of lowering quality, making it more difficult (e.g. out of work time) and costly for teachers to access CPD, weakening employer support and increasing the number of private providers. Further research would be welcome to determine to what extent trade unions representing health professions are dealing with CPD. From ETUC's perspective, workplace health and safety courses should not be considered by employers as profession-related CPD since these are linked to general workplace conditions, thus they are a must in all work places.

Hospital pharmacy perspective

The European Association of Hospital Pharmacists (EAHP) is an association of national organisations in 34 countries representing hospital pharmacists at European and international levels. The Association has followed developments in relation to the modernisation of the Professional Qualifications Directive closely, especially in respect of their ambition to form a 'common training framework' to give greater mobility to the hospital pharmacy specialisation.

EAHP consider that CPD conducted by health professionals should be related to the individual's area of practice and offer patient safety benefits (i.e. some criteria required as to eligibility). Referring to what they see as an internationalisation of education, especially in specialist areas, they see a need to ensure CPD conducted in other countries (e.g. Congresses) can be recognised by an individual's home competent authority. This might also apply to online learning programmes hosted and developed in another country.

Technology is facilitating the easier and more flexible provision of learning opportunities for healthcare professions. For example, in hospital settings CPD sessions can be organised for lunch times and evenings, in a multi-disciplinary format, via either live speakers or online/tablet driven provision.

EAHP emphasised the importance of employers both permitting and encouraging their employees in the pursuit of CPD. Failure in this respect can create heavy burdens and barriers for individuals, including meeting costs, such as lost working time and fees associated with learning events/online programmes.

EAHP saw a potential role for the new European Professional Card (EPC) in respect of adding to the transparency of CPD conducted by an individual. For example, information could be included on an individual's record of the CPD they have conducted in the past 5 years (certificates, etc.). This might be provided on a voluntary basis in the first instance

OECD perspective

¹¹¹ McKinsey Center for Government, 'Education to Employment: Designing a system that works', http://mckinseysociety.com/downloads/reports/Education/Education-to-Employment_FINAL.pdf

¹¹²

http://etuce.homestead.com/Crisis/Crisis_survey/Results_of_ETUCE_Minisurvey_on_Crisis_effecting_teacher_education_.pdf

A representative of the OECD confirmed the findings of an OECD paper on skills mismatches in the health sector¹¹³ and stressed the fact that there appears to be a mismatch between CPD content and skills development needs.

The OECD paper was produced as part of a bigger health workforce project in collaboration with DG SANCO. It discusses the findings of two multi-country surveys (the 2011-12 Programme on International Assessment of Adult Competences [PIAC] conducted in 21 OECD countries and the 2010 European Working Conditions Survey [EWCS] undertaken in 34 European countries) which highlight the problems of over- and under-skilling as experienced according to self-reports submitted by doctors and nurses. Over-skilling means that workers feel their skills are above the tasks they are actually performing whereas under-skilling describes a situation whereby workers feel they would require more training to cope with their allocated tasks. However, the paper does not go into CPD content and hence problems related to this remained unknown.

The OECD representative confirmed that skills mismatch represents a challenge in the health sector rather than qualification mismatch. It was stated that the issue appears to be related to CPD quality rather than quantity, since many doctors undertook CPD and yet the extent of reported under-skilling was found to be especially high for this professional group. Hence **CPD is a potential policy lever for resolving the issue of under-skilling** that contributes to quality assurance and workforce management.

The OECD feels in particular that further targeted EU-level research into skills needs is vital. A macro-level analysis would be advantageous as the problem appears to be structural. Moreover, there is a need for developing and disseminating further knowledge about CPD at European level, including data on who offers relevant activities, since it is important to find an effective balance between the interests of learners and CPD providers.

EU study on effective recruitment and retention for health workers

Finally, two conversations were held with members of the consortium for the study on 'effective recruitment and retention strategies for health workers' conducted for the CHAFEA and co-managed by DG SANCO as part of the Action Plan on the EU Health Workforce implementation. One of the aims of this study is to identify whether CPD plays an identifiable role in interventions pertaining to the recruitment and retention of health professionals in Europe. Following an extensive literature review and expert discussions, this will further be explored through case studies in the area of lifelong learning.

The preliminary findings of this study confirm that, although CPD offers can act as important pull factors for migrating health professionals in countries where the offer is limited, in Europe it is rarely used as a distinct policy strategy for improving recruitment and retention. Moreover, there appears to be little evidence in the available literature of effective interventions that can help attract and retain health workers in general, primarily due to lack of evaluation. Countries where CPD has been used for this purpose are mainly outside of Europe (e.g. South Africa, United States, Canada) whereas in EU/EEA countries efforts have concentrated on descriptive aspects of CPD (e.g. use of eLearning tutorials in Norway, CE programmes for family health units in Portugal) rather than its links with recruitment and retention

Nonetheless the consortium has been able to establish that health professionals are very sensitive to opportunities afforded to them in another Member State if these match their sets of expectations. The latter include, apart from better remuneration, prospects for career progression including through CPD offers. According to the literature consulted by the consortium, CPD is thus an integral part of health

¹¹³ The OECD paper will be released on 30 Sep 2014, reference to be added then

professionals' expectations and the question is how to address this in terms of recognition of CPD activities and 'rewarding' individuals.

Overall, the preliminary study findings suggest that better recruitment and retention policy for health professionals implies comprehensive measures that might include, *inter alia*, financial and personal support incentives, as well as CPD. Hence it will be important to establish what kind of CPD health professionals want and need, what the access barriers are, and how CPD improvements relate to other aspects of health workforce policy (i.e., what other measures are required to discourage migration). It is thus about more than ensuring that CPD 'counts' through credit systems and other instruments, as also acknowledged by the overarching theme agreed upon by the consortium for the future case studies, 'Creating health workplaces people want to work in'.

Conclusions

The findings of the first literature review led to the question whether establishing a stronger link between CPD and clinical / professional practice, without becoming overly prescriptive in terms of requirements, yet strengthening quality assurance, could be one way of achieving greater awareness and discursive acceptance of CPD. This might consequently also lead to a stronger implementation effort. It noted that the link between the application of CPD learning outcomes to practice and high quality patient care needs to be explicit (Horsley, Grimshaw and Campbell, 2010). It also touched upon the question as to whether it will become more important to establish an evidence base in order to determine whether or not it is advantageous for CPD in Europe to remain as diverse as it is now between different professions and countries or whether it should become more 'coordinated'. The latter would imply that content, activities, delivery modes and purposes could be more aligned. The literature confirmed the need to conduct further profession- and country-specific research on CPD outcomes and effects on clinical practice in addition to investigating the links between assessing learning/practice outcomes and existing qualifications and/or competency frameworks in the health professions.

By looking at CPD within the wider landscape of LLL, and taking into account the lessons and findings of European initiatives developed by the EC, the sectoral health professions and other CPD actors, the present inventory set out to examine the following questions:

- What initiatives on CPD and LLL are carried out at the EU level?
- What initiatives on CPD and LLL exist at European level outside the EU context?
- What aspects of CPD and LLL are addressed by these initiatives (e.g. relating to accreditation, transparency, quality, transferability)?
- How do these initiatives come into being (motivation, actors involved, process)?
- How do these initiatives relate to national systems?

As demonstrated by the existence of a wide range of instruments to make transparent national education and training and skills qualifications, initiatives put into place by the EC have largely arisen out of the need for increased coherence in the areas of education and training, employment and mobility, and in support of pursuing Europe 2020 strategy goals in an effective Single Market. The cautious inclusion in the revised Directive on the recognition of Professional Qualifications of EQF and ECTS illustrates the growing awareness that tools developed for different systems within LLL have value that goes beyond their original application. Yet there is an important difference between the understanding of a qualification under the Directive (the result of a successful participation in an education / training process) and the sets of descriptors introduced by the ongoing education and training reforms, which assume that the same knowledge, skills and competences can be attained through different types of learning (GHK, 2011).

The observed shift to learning outcomes derived from formal and informal learning activities is nonetheless contributing to a modernisation of education and training systems by placing greater emphasis on LLL (including CPD). In this way mobility of various categories of learners beyond the highly educated is promoted while facilitating a better understanding of qualifications at all levels.

The Commission's focus on LLL has also stimulated CPD-related initiatives by the sectoral health professions, other health workers and professional sectors/stakeholders external to the EU. This has occurred both in a reactive and proactive fashion, in coordinated and ad hoc ways. Overall, this literature review reveals an increased focus on defining and recording professional knowledge, skills and competences obtained in various educational settings, to promote understanding professional aptitude and cross-border mobility. Moreover, there are efforts to develop accreditation systems at national and European levels to provide quality assurance of CPD activities.

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Judging from the sources consulted, it would appear that a number of European initiatives contain elements potentially interesting for the future development of CPD in the health sector. The background document to the stakeholder consultation on the European Area of Skills and Qualifications (EC, 2013) categorises the European tools for ‘transparency and recognition of skills and competences’ described above into eight different categories. Amongst others, these include qualifications frameworks (e.g., EQF), quality assurance arrangements (e.g., EQAVET), credit systems (e.g., ECVET) and documentation tools (e.g. Europass). Yet while these are meant to build on one another and evolve in line with changing LLL priorities, it is not always apparent how they complement each other. For example, the evaluation of the EQF (EC, 2013), which is a kind of meta-framework for all other tools discussed in this review, noted a lack of coherence with quality assurance tools.

At the same time, EQF in particular is an example of a system based on trust between national, regional and sectoral level stakeholders operating within their own frameworks yet collaborating at European level. This is a potentially useful lesson for health professional CPD where it may also not be possible to fully align the systems in place.

The literature also suggests that qualifications frameworks are political tools increasingly developed and implemented worldwide. Any efforts to ‘streamline’ them demonstrate the desire to increase the understanding between knowledge, skills and competences acquired in different international educational and professional settings. On the other hand, as noted by Bohlinger (2012:283), ‘developing qualifications frameworks resembles the introduction of a new currency, which everybody wants, but whose meaningfulness is (yet) unclear’. Due to lack of evidence regarding the effectiveness of qualifications frameworks, it is uncertain whether they could be useful tools for solving the transparency and recognition problems experienced by the CPD community. However, in theory they can encompass CPD, and the fact that EQF is being referenced across Europe shows that national systems can adapt without relinquishing national particularities (e.g., the dual system).

ECVET, although focused on initial vocational education, represents a tangible technical framework that includes ‘further instruments, as well as a methodology for the description of units of learning outcomes, including the alignment of points/credits and a credit transfer and accumulation process’ (Küßner, 2012:48). As projects in areas as different as nuclear energy and transport/logistics demonstrate, its flexibility allows for transfer of this approach to different professional settings and for national adaptation, while further developing the principle of international collaboration contained in the 2006 Council Recommendation on a Quality Charter for Mobility¹¹⁴.

As the expert consultations conducted in conjunction with this review have brought out, it is important to recall that ECVET and ECTS, as well as the qualifications frameworks, were developed in a specific context for specific purposes, and while some of the features – in particular, the promotion of learning outcomes – invite consideration in the CPD context, in practice these templates may not work since the different national professional and educational cultures and work settings come into play more strongly in the healthcare sector than in other disciplines, and even more strongly in CPD given the distinctive significance of workplace learning.

It is also important to reiterate that CPD is not a qualification that requires a time-limited learning effort (but will eventually be attained), but that it describes a process that only ends once an individual is leaving their profession for good. Given the pressures and ever-present changes of the healthcare sector, this process is of paramount importance.

¹¹⁴ Recommendation on transnational mobility within the Community for education and training purposes: European Quality Charter for Mobility, 2006/961.

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The fact that deployment of the EU level tools is voluntary can be viewed either in a positive or a negative light. One positive effect is that international cooperation encourages developing and testing non-legislative solutions based on mutual trust and understanding gained from new partnerships, resulting in 'the joint search for, and dissemination of, best practice and the development of common benchmarks and guidelines' (Dehmel, 2006:54). This could lead to developing compromise solutions that provide the 'best fit' for meeting national and professional CPD needs, thereby also contributing to improved patient safety.

The European mapping studies carried out by the health professions and other stakeholders all vary in their research designs, methodologies, comprehensiveness and objectives. They include particularly useful information on the commonalities and differences in CPD delivery, content and validation, data that also served as background information for the initial stages of this study. They provide a rationale for ensuring that CPD must closely relate to core activities and professional needs, as these are distinctive for each profession.

At national level, it appears that the application of EU instruments is still in an exploratory phase. Rather than copying EU templates, stakeholders are adapting EU instruments to national and professional contexts which, as in the case of CPD, do not always invite straightforward alignment. For example, the descriptors, levels and indicators of European tools often differ from those developed at national level. Moreover, the concepts of units of learning outcomes and credits differ, e.g. even between ECTS and ECVET (EC, 2013).

It is virtually impossible to draw concrete conclusions from the available literature given the dearth of studies specifically exploring the interplay between initiatives in higher / vocational education and training, employment, mobility and their influence on the organisation of CPD systems. Hence targeted EU-level research into these relationships could be useful in order to avoid indiscriminate mixing of CPD with different education systems.

Regarding patient safety, the literature suggests a lack of evidence regarding CPD's demonstrated benefits (Eaton et al., 2011). More research into the broader dimension of patient safety, including its relation to education and training, could be beneficial since the current EU framework is predominantly focused on patient safety and quality of care as such.

The following points can nonetheless be derived from this review. If purely regarded as templates for encouraging flexible learning pathways, permeability and facilitating intelligibility of what mobile professionals actually know and are able to do, ECVET, ECTS, EQF and other tools provide interesting approaches and ideas on how to make CPD more transparent. Transferable credits in particular appear to be useful. If taken as easily replicable models however, the findings suggest there might be too much complexity and too little evidence for them to be practicable in the health professional CPD context. This could be related to the distinct regulatory frameworks of undergraduate / postgraduate and vocational education and training, but also to the difficulty of reconciling so many different criteria and systems.

Most importantly though, given this study's confirmation of the inherent diversity of CPD, the majority of stakeholders consulted expressed an interest in more European-led exchanges of practices to strengthen national systems. This could help the different actors who are developing and accrediting CPD activities at national and European level to work more efficiently together and encourage the sharing of good practices, e.g. especially regarding important curriculum elements such as interdisciplinary CPD and patient safety. It could also include direction on standard setting and making best use of voluntary mechanisms, without resorting to EU-level harmonisation of CPD which could work to the detriment of individual learners and health systems.

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Annex 1 – Detailed project descriptions

- 2get1care¹¹⁵

The project (2010-) tested the ECVET system for healthcare professions in Germany within a European partnership to develop an approach to make qualification components more accessible and transferable, on an inter-professional level as well as transnationally. The European partnership consists of a leading German continuing education provider and two universities in Germany, as well as VET and research institutions in Austria, Hungary and Czech Republic. The project adapted the training curricula of four healthcare professions (occupational therapy, speech therapy, physiotherapy and geriatric care) to ECVET standards, developed a common core curriculum and a further training concept based on ECVET principles for teaching staff.

Of specific interest in the context of CPD, the project includes the implementation of ECVET at the level of professional further training, and the development of the latter concept in accordance with ECVET principles, i.e. focused on learning outcomes. After the completion of the pilot, the project products will be further developed and adapted to the ECVET system in Germany, and it is hoped that a sustainable European network will remain in place.

- EUSAFE

The 2010 EUSAFE - European Qualification for Occupational Safety and Health (OSH) professionals - project¹¹⁶ provided a new professional qualification and training framework for OSH professionals, based on already existing certification standards and EU instruments. The aim was to achieve effective competences, qualification transparency and recognition, and to improve EU mobility by tackling barriers to transparency and harmonisation of training requirements and qualifications.

In particular, the project uses the EU instruments mentioned above - EQF, ECTS, ECVET - and the two voluntary European certification standards (EurOSHM and EurOSHT) developed by the European Network of Safety and Health Professional Organisations (ENSHPO). The outcome is a range of standardised profiles (EQF levels 4, 5 and 6) to cover the different levels of qualifications and roles of OSH professionals.

Tools were created with the involvement of national organisations and institutions who will validate the proposed qualification. This involvement should convince the validating institutions of the necessity to include in their approved schemes training programmes that are harmonised with the training objectives of the EurOSHM and EurOSHT standards.

- Tuning project

As the debate over core competences in nursing is ongoing, the Tuning Educational Structures in Europe project (2000 – 2008) served to define general health professional competences provided by university degree programmes and the specific competences linked to each profession, including nursing (Bagnasco et al., 2012).

The interest of this for CPD lies in the shift from problem-solving competences to defining 'systemic' competences that involve critical thinking and a broader understanding of health system issues and roles, especially given the new approach towards working in inter-professional teams and improving quality of patient care.

- Support structures for ECVET and EQF application in Europe (2012):

This German project is an example of how the implementation of EU transparency tools - EQF, ECVET, EQAVET – requires support for integration into national VET practice by development of support structures and tools (e.g., online portal, consultation forum, guidelines, workshops, and tutorial)

- Recognition and validation of non-formal and informal competencies in the context of National Qualification Frameworks (2011, Germany)

¹¹⁵ <http://www.adam-europe.eu/adam/project/view.htm?prj=7646#.UywCpKhdWSo>

¹¹⁶ <http://www.adam-europe.eu/adam/project/view.htm?prj=6842>

Another German based project aimed to encourage mobility in the context of the EQF's comparability of learning outcomes. It is about the validation of non-formal and informal learning outcomes, their translation into skills and competences, and how to measure and compare these in a scientific way. It used the so-called KODE® model including its Atlas of Competences as a basic instrument for structuring the competences of EQF and the National Qualifications Frameworks (NQF).

- ECVET-path for LLL (2011)

This project produced a manual on "How to create your individual LLL path" in order to help individuals to recognize and validate learning outcomes acquired during their lifetime. The manual will help individuals to create portfolios, assessed to specific professional reference frameworks and validated following the EQF and ECVET levels.

Portfolios also play a big role in CPD where they serve in many frameworks as self-evaluated evidence of having undertaken relevant CPD activities and reflection.

In the context of demographic change and staff shortages in elderly and social care and the increased need for quality assurance in the social sector (Cedefop, 2010), this project enables persons without regular qualifications but with relevant knowledge gained during their lifetime to recognize and validate their learning outcomes obtained through formal, informal and non-formal learning, in response to the Bruges Communiqué on enhanced European Cooperation in VET for the period 2011-2020. Paths to empowering people for their LLL activities were developed and they also internationalized VET by merging partners' experience and training competences in the healthcare/ social care sector.

- Creating a common foundation in care with the ECC (2009)

This two-year project expanded the European Care Certificate (ECC) to 17 countries. The ECC provides evidence that the holder knows the basics needed to work safely in social care; it is based around the Basic European Social Care Learning Outcomes which cover entry level knowledge in 8 key areas of care. The ECC does not test competence, only knowledge, but it asks students to apply that knowledge in a series of questions which do require some careful thought. It is an agreed set of learning outcomes and an exam producing a certificate which can be taken anywhere.

The ECC 'fits inside' any existing award, in any language at any level in any country. The market is huge with a largely female unqualified workforce. The ECC helps employees find a job and provides employers with confidence that applicants know the basics in care. It is inexpensive to do, easy to access in various languages and there are no 'set courses' to follow - learning takes place in many different ways. Any college or employer can deliver it and also have their learning course passed as being 'ECC compliant'.

The project also created national networks of ECC supporters and attempts were made to link ECC to EQF and NQFs.

- Competence standards of professional education and further education in the sector of geriatric care (2009)

The development of competence standards in the professional education of geriatric care and the definition of scales for the adequate recognition of competences acquired through formal, non-formal and informal learning is a prerequisite for linking education and labour market policy in this sector.

In the project partnership the methodology developed in other sectors was taken up and transferred for the sector of geriatric care for competence based description occupations. The Leonardo da Vinci projects "ECTS for chemistry worker" and "EQF chemistry" provided a methodology for elaborating competence standards and knowledge proved by performance points, got skills and competence which was transferred to the sector of "geriatric care" developed. Better planning and implementation of mobility measures in this sector enable increased freedom of movement on the EU labour market in the context of East-West migration of health professionals. The partner countries included DE, OT, IT, SK, PL, TR and jointly they worked on standardisation/harmonisation of outcome-oriented education and further education. This also helps prevent ethical and racial barriers to the participation in the European labour market in the sector.

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- Intercultural education of nurses in Europe (2010)

The migration of nurses and populations is a challenge to the delivery of culturally competent care. The project IENE2 contributes to the improvement in quality of vocational education and training of nurses in Europe.

It adapted and integrated the innovative transcultural nursing education model developed in the previous Leonardo da Vinci Partnership IENE 1 project 'Intercultural education of nurses and medical staff in Europe'. The implementation of the IENE2 model in IVET and CVET systems in four partner countries enabled nurses and other healthcare professionals from the partner countries to acquire transversal and transcultural key competences and new skills in order for them to be able to adapt to a variety of tasks in their working lives and provide culturally competent care.

The transfer methodology was made in three steps: 1) the partners conducted research on the specific competences necessary to provide transcultural education to various categories of nurses and healthcare professionals from the project countries. The results were used to design the objectives of the Training of Trainers (ToT). Training modules and materials were created and four workshops were organized in in BE, DE, RO, FR and the teachers and trainers were prepared for implementing the model. 2) the model was adapted and piloted in initial and continuing education and training of nurses in four partners' countries. Ten pilot implementation projects were carried out successfully. 3) the final products are available for integration in regional, national and European IVET and CVET systems.

- SEALLL (Self-evaluation in adult LLL)

SEALLL aims to improve the quality of teaching and learning and the quality of organisation and management in LLL by promoting and supporting self-evaluation as a learning process. The project wants to help all 'players' in LLL-organisations self-evaluate their teaching, learning and management.

It includes a set of materials to facilitate a culture of self-evaluation and to create and execute self-evaluation processes in organisations to ensure quality care. It takes a bottom up approach by guiding the 'initiators' in the process of conducting their own evaluation. The tool advocated by SEALLL starts from a modular framework where 'self-evaluation as a dialogue in a multiplayer situation' is the key-concept. A dialogue between staff, teachers and learners within the institution and a dialogue between the institution and relevant external actors is the starting point for self-evaluation.

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Annex 2 – Expert consultations with European CPD stakeholders

The following questions were provided to the experts identified by the consortium. They were meant to function as guiding questions that individuals were free to answer if appropriate. Most respondents felt that not all questions were applicable to their area of competence; hence the focus of the consultations lay predominantly on the last question, which also helped respondents make connections with the other areas covered by the study:

- Is there an EU level (or European wide) CPD framework in the particular area you are representing)?
- Can you see any relation or impact between the developments in your area of CPD engagement and sectoral health professions' CPD?
- How does the organisation of health education (e.g. controlled by sectoral professions, higher education institutes, etc.) impact on the organisation of CPD, i.e. mandatory or voluntary?
- Do you believe there can be further CPD harmonisation across Europe?
- What can be acceptable across Europe, i.e. transferable education credits or CPD accreditation systems?
- Is there evidence that CPD is having a positive impact (e.g., results of evaluations regarding its impact on patient safety)?
- What future trends will influence CPD?
- Are there any EU tools (e.g., EQF, ECVET, ECTS) that might be helpful in the context of health professional mobility / transparency about qualifications?
- **(Any other issues you feel should be touched upon by the study)**

List of individuals consulted for 'European perspectives' section:

- Mathias Maucher, Policy Officer (Health and Social Services), European Public Service Union (EPSU), 28 March 2014 (in person)
- Carlo Scatoli, Policy Officer (Continuing VET), DG EAC, European Commission, 28 March 2014 (in person)
- Thomas Zilling, European Association of Senior Hospital Physicians (AEMH), 28 March 2014 (e-mail)
- Janet Grant, Professor of Medical Education, Open University, 2 April 2014 (telephone)
- Gerd Dielmann, German trade union ver.di (former head of division), 3 April 2014 (telephone)
- Richard Price, Policy and Advocacy Officer, European Association of Hospital Pharmacists, 14 April 2014
- Frédéric Destrebecq, Acting CEO, European Union of Medical Specialists (UEMS), 23 April 2014 (in person)
- Kate Ling, Senior European Policy Officer, NHS European Office, 25 April 2014 (in person)
- Professor Rafal Nizankowski (colleague of Basia Kutryba, Reference Network & Patient Safety Working Group member), 6 May 2014 (telephone)
- Pascal Garel, Chief Executive, European Hospital and Healthcare Federation (HOPE - Hospitals of Europe), 16 May 2014 (in person)
- András Zsigmond, Seconded National Expert / Policy Officer, DG MARKT, 26 June 2014 (in person)
- Agnès Roman, Policy Advisor (LLL issues), European Trade Union Confederation (ETUC), 2 July 2014
- Eugene Pozniak, Programme Director, European CME Forum, 2 July 2014 (telephone)
- Anita Kremo, Policy Officer (Skills and Qualifications - EQF and learning outcomes), DG EAC, European Commission, 4 July 2014 (in person)
- Gilles Dussault, International Public Health and Biostatistics Unit, University of Lisbon, 12 September 2014 (telephone)
- Tjitte Alkema, Secretary General, HOSPEEM, 18 September 2014 (telephone)
- Walter Sermeus, University of Leuven, 18 September 2014 (telephone)

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- Michael Schoenstein, Economist (Health Division), OECD, 24 September 2014 (telephone)

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