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

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ANNEX VI – WORKSHOP DISCUSSION PAPER

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INTRODUCTION

Against the background of the ageing population, prevalence of major chronic diseases and increasing scientific and technological changes, the need for adequate numbers of health professionals with relevant education and training has been clearly recognised at European level. In particular, a number of recent EU policy initiatives and legislation underline the importance of regularly updating and improving skills of health professionals through lifelong learning (LLL) and continuous professional development (CPD)[1] [2], to improve quality of care and patient safety [3], and to avoid skills mismatches and workforce shortages[4]. According to the amended Directive on the recognition of Professional Qualifications [5] Member States 'shall ensure that professionals are able to update their knowledge, skills and competences to maintain safe and effective practice'. The Directive introduces an exchange of information and best practice for optimising CPD in the Member States.

Significant differences in CPD in healthcare exist in EU, EFTA and EEA countries and there is a lack of comprehensive studies that would allow comparison and meaningful dialogue across countries and professions.

In this context, the consortium consisting of the Council of European Dentists (CED), the European Federation of Nurses Associations (EFN), the European Midwives Association (EMA), the European Public Health Alliance (EPHA), the Pharmaceutical Group of the European Union (PGEU), led by the Standing Committee of European Doctors (CPME) were contracted by the Consumers, Health and Food Executive Agency (CHAFEA) and funded by the Health Programme to carry out a 12 month study concerning the review and mapping of CPD and LLL for five health professions (doctors, nurses, dentists, midwives and pharmacists)[6] in EU, EFTA and EEA countries.

Launched in October 2013, the study consists of a literature review on CPD and LLL concepts, a second literature review on European level initiatives, an online survey of national CPD systems in 31 countries, and a technical workshop. It aims to:

- Provide an accurate, comprehensive and comparative account of CPD models, approaches and practices for health professionals and how these are structured and financed in the EU-28, and the EFTA/EEA countries; and,
- Facilitate a discussion between organizations representing health professionals and policy-makers, regulatory and professional bodies to share information and practices on the continuous professional development (CPD) of health professionals and to reflect on the benefits of European cooperation in this area for the good of the patients of Europe.

For the purposes of the study, the following **definition of CPD** is used:
The systematic maintenance, improvement and continuous acquisition and/or reinforcement of the lifelong knowledge, skills and competences of health professionals. It is pivotal to meeting patient,

[1] Green paper on the European workforce for health, COM(2008) 725 final
[2] Council Conclusions on investing in Europe's health workforce of tomorrow: Scope for innovation and collaboration, 7 December 2010
[3] Council Recommendations of 9 June 2009 on patient safety, including the prevention and control of healthcare associated infections, OJ C 151 3/7/2009
[4] Action Plan for the EU health workforce, SWD(2012)93 final
[5] Directive 2005/36/EC on the mutual recognition of professional qualifications, amended by Directive 2013/55/EU
[6] Sectoral health professions as defined in Directive 2005/36/EC on the mutual recognition of professional qualifications, amended by Directive 2013/55/EU

health service delivery and individual professional learning needs. The term acknowledges not only the wide ranging competences needed to practise high quality care delivery but also the multi-disciplinary context of patient care. [For example, this might include technical, scientific, regulatory and ethical developments, as well as research, management, administration and patient-relationship skills. Activities can be categorised as formal/informal and mandatory/voluntary.]
A literature review on CPD and LLL concepts has been completed looking at publications on the discourse on CPD, national CPD systems, and European level initiatives. The latter is still being elaborated through further interviews with experts and comments received from the Reference Network. The online survey was carried out between 20 January and 20 March 2014 and was aimed at the competent authorities responsible for CPD at national level and/or professional bodies at national level. By 20 March, replies from all but 4 contact points were received and were taken into account for the analysis. The survey findings are still being validated by national contact points.

▪ Aims of the technical workshop

The technical workshop, which will take place in Brussels on 20 June 2014, will bring together up to 60 experts and stakeholders in the area of CPD for the five sectoral health professions, including representatives of professional and regulatory bodies, CPD providers, academics, accreditation bodies, relevant EU projects and initiatives, and the European Commission. The participants are expected to comment on the initial findings of the study and to provide information to fill any gaps in the data collected.

The structure of the workshop will allow for active involvement of the participants, particularly through four parallel breakout sessions which will be designed around horizontal issues. The total number of participants of the individual breakout sessions will be limited to stimulate dialogue. In addition, a plenary discussion will be held on the value and modalities of possible European cooperation on CPD for health professionals.

Results of the workshop will be processed, together with the findings of the literature reviews and the survey, into a final report for the study in October 2014 which will include policy recommendations.

▪ Aims of the discussion paper

The purpose of this discussion paper is to provide participants of the technical workshop with information about the findings of the literature reviews and the survey, as well as to point out gaps in knowledge and to suggest questions to direct the discussion during the workshop.

▪ PRELIMINARY FINDINGS OF THE STUDY

CPD systems vary considerably across EU/EEA/EFTA countries and across the sectoral health professions. While common threads can be found within national health systems, most significant commonalities are found within individual professions and generally reflect whether the majority of the health professionals work as self-employed or as salaried employees, whether they work within the statutory health system and whether they belong to a professional body with its own CPD system.

▪ Mandatory and voluntary CPD

CPD is mandatory[7] for the majority of the 5 sectoral professions in most of the 31 countries surveyed: 19 countries for doctors and midwives, 20 countries for dentists and pharmacists and 21 countries for nurses. In addition, a significant number of survey respondents anticipate that CPD will become mandatory in the next few years; this is often supported by the profession as there is an assumption that greater formalisation and regulation of CPD would address existing structural deficiencies such as inadequate funding and lack of employer accountability, most often described as failing to allow health professionals to participate in CPD during working hours.

The requirement for mandatory CPD is most often expressed in terms of duration (number of credits or hours) or content, or a combination of the two. Criteria based on learning outcomes and minimum number of CPD activities are deployed more rarely. The reported prescribed duration varies widely between 20 and 50 credits/hours per year for doctors, 10 and 100 for dentists, 4 and 60 for nurses, 4 and 80 for midwives and 3 and 50 for pharmacists (average over a reference period of between 1 and 10 years)[8]. Prescribed content was reported by around a third of respondents for nurses and a half of respondents for doctors, with other professions falling in between. CPD requirements may differ depending on the health professional's seniority, specialty or position.

Voluntary[9] CPD frameworks exist in 22 countries for dentists, in 18 countries for doctors, in 15 countries for midwives, in 12 countries for nurses and in 11 countries for pharmacists. Voluntary CPD frameworks have less defined recommendations of duration and content than mandatory CPD systems, recommended duration is reported to be as much as 15 days per year and positive incentives, like increased salaries or paid leave to undertake CPD activities, etc., are more commonly offered, by professional organisations above all.

The survey results suggest that the distinction between mandatory and voluntary CPD might to some extent be artificial as both categories encompass many different arrangements. Mandatory CPD can be based on a clearly defined requirement, sometimes directly linked to revalidation[10] or it can be only a general obligation in which case it might be unenforceable. In other cases, voluntary CPD is de-facto mandatory for a part of the profession, for instance for the professionals working in the statutory health system or under an insurance scheme, or is based on a requirement set by an individual employer. There are also examples of professional associations establishing their own CPD requirements for their members resulting in a significant percentage of the profession participating in CPD. Mandatory and voluntary systems often co-exist and may have separate structures and requirements or may be interlinked by the same CPD activities fulfilling the requirements of both.

[7] For the purposes of the study, mandatory CPD is « CPD that is **mandatory** for a professional, on the grounds of predefined requirements set by a competent authority (e.g. regulator or professional body), sometimes related to relicensure, re-registration or revalidation Mandatory CPD may require activities to fulfil, e.g., minimum requirements pertaining to the number of study days or credits to be gained in a set time period, the number of study days needed in a set time period, requirements for providing evidence of the CPD activity or other requirements. It may encompass both formal and informal CPD activities."

[8] Data is not directly comparable due to different national definitions of credits and hours and is provided as a rough indication only.

[9] For the purposes of the study, voluntary CPD is «CPD that is **not mandatory** for a professional on the grounds of predefined requirements set by a competent authority (e.g., regulator or professional body) and is in particular not related to relicensure, re-registration or revalidation, regardless of whether or not there are professional guidelines in place for the profession in question. It may encompass both formal and informal CPD activities."

[10] For the purposes of the study, revalidation is "the process through which registered health professionals demonstrate periodically that their knowledge is up-to-date and their continuing fitness-to-practise. It can be a tool for showing that CPD activities undertaken are appropriate for supporting and enhancing professional practice. It may be a prerequisite for relicensure and re-registration, and can be tied to professional appraisals."

▪ Compliance and enforcement

Compliance with both mandatory and voluntary CPD is most often monitored by professional bodies with regulatory competences or by professional associations, as it is the case for doctors, dentists and pharmacists. Compliance with mandatory CPD is in addition normally monitored by Ministries of Health for nurses and midwives. Compliance is enforced at national rather than at regional level in almost three quarters of cases.

Where mandatory CPD systems exist, compliance is reported to be linked to revalidation[10] in about half of all cases[11], ranging from 60 percent for midwives to 43 percent for dentists. The most common sanctions for not complying with mandatory CPD are temporary suspension of professional licence, reprimand by a professional body and immediate loss of licence. In addition, 21 percent of all respondents indicate that there are no consequences of not complying with a mandatory CPD requirement.

Compliance with voluntary CPD is most often monitored by a professional body with regulatory competence or a professional organisation for all professions, as is the case also with monitoring of mandatory CPD participation. However, a much larger percentage of professionals report that no monitoring of voluntary CPD is necessary (50 percent of pharmacists, 47 percent of doctors and 33 percent of dentists) or that monitoring is up to the individual professional (29 percent of midwives and 25 percent of nurses), underlining the importance of self-evaluation and professionals' responsibility to undertake CPD.

There are usually no direct consequences if a professional does not follow recommendations under a voluntary CPD framework but some serious consequences for not complying with voluntary CPD have been reported. These include a reprimand by a professional body, fewer career progression opportunities, lower payment rates under a national health system or being expelled from a professional association.

▪ Content, providers and forms of delivery

Across all five health professions content of formal CPD activities is most often developed by professional bodies, followed by scientific societies (especially for doctors, dentists and pharmacists) and higher education institutions. The private sector/commercial also plays a prominent role for doctors, dentists and pharmacists.

Prescribed content for mandatory CPD was most often reported for doctors (more than half of respondents) and least often for nurses (around one third of respondents). For doctors it is most likely to be based on speciality or grade; for nurses and midwives it is often prescribed by the employer. Content appears not to be based on a needs assessment process, either at individual or professional level as almost half of respondents for nurses and midwives indicate no needs assessment takes place, increasing to 70 percent of replies for pharmacists.

[11] Doctors: CZ, DE, HR, HU, LT, LV, NL, NO, RO, SI, UK
Nurses: BE, BG, CY, CZ, HR, IE, LT, LV, NL, RO, SI, UK
Dentists: BE, DE, HU, HR, LT, LV, RO, SI, UK
Midwives: BG, CY, CZ, HU, HR, LT, LV, NL, RO, SI, SK, UK
Pharmacists: HU, IE, LT, LV, NL, PL, PT, RO, SI, SK

Professional organisations are the main providers of CPD for dentists, nurses and midwives, closely followed by scientific societies. The leading provider of CPD for doctors are scientific societies and for pharmacists the private/commercial sector.

Most CPD is conducted through conferences, symposia, lectures and seminars (mentioned by almost all respondents), followed by case presentations (mentioned by three thirds). eLearning was of increasing importance and was reported by as many as three thirds. Health professionals are also likely to follow CPD with other professions and multi-professional CPD was reported by a large proportion of respondents, ranging from 36 percent for nurses to 82 percent for midwives (doctors: 67 percent, dentists: 68 percent, pharmacists: 71 percent) . The survey also asked about CPD offered by patients which appears to be rare and was reported by the smallest number of respondents out of 20 suggested forms of delivery.

▪ Financing and transparency

Self-funding by the health professional is the leading source of financing for CPD activities across the five professions. Another common funding source is the employer which is most relevant to nurses and midwives and least relevant to dentists. The private /commercial sector is particularly important for doctors and pharmacists. Generally, there are no rules in place governing the pricing of CPD activities which is likely to be reflective of the diversity of providers and types of activities available.

The survey also explored the existence of guidelines or codes established to ensure the transparency and independence of CPD, which the consortium thought to be important in view of private/commercial sector involvement in development of content, provision and financing of CPD. Such guidelines exist for more than half of respondents. They are more often reported for doctors and less often for nurses due to the employer being responsible , and are most often based on a code by the professional body and less often on a national law (sometimes generic legislation is applicable). Pharmacists are most likely to have rules on communicating information about CPD activities as nearly half of all countries reported having rules or legislation on medicine advertising or commercial sponsorships for pharmacists' CPD.

▪ OPEN ISSUES AND DISCUSSION QUESTIONS

In the following, please find a brief introduction to specific questions, which will be addressed in the plenary session and the four parallel break-out sessions. We invite you to reflect on the discussion questions in preparation of the workshop.

▪ *Breakout session:* Trends in CPD for health professionals

Moving from voluntary to mandatory CPD appears to be a leading trend across a number of countries surveyed. Over the last five years, CPD became mandatory for doctors in Greece and Ireland, for nurses in Cyprus, for salaried dentists in Italy, and for pharmacists in France and Latvia. Moreover, there are expectations that in the near future CPD will be made mandatory in five additional countries for doctors, in three countries for nurses and dentists, and in two for midwives and pharmacists. **Revalidation schemes**[10] linked to CPD are expected to be introduced as part of the current review of regulation of health care professionals in the United Kingdom.

Changes in criteria for accreditation of CPD are also widely reported. Apart from Italy, where a recent shift from accreditation of CPD activities to accreditation of CPD providers affected all health

professions, particularly the accreditation of doctors' CPD appears to be undergoing significant changes. For doctors, a number of countries reported to be moving closer to the UEMS – EACCME® accreditation framework. In addition, particularly pharmacists and doctors report the development of **new competency and qualifications frameworks** with direct impact on CPD.

Other, less frequently reported trends include increasing importance of **quality assurance in CPD** for doctors in Austria, greater reliance on **learning outcome-based CPD and competence assessments** (reported by dentists and nurses in France and by pharmacists in Ireland and the Netherlands) and greater relevance of **reflection** as a part of the CPD cycle for midwives in Switzerland. In some cases there also appears to be greater attention given to the health professional's individual interests and responsibility for CPD through introduction of **personal development plans** for doctors in the Netherlands, dentists in the United Kingdom and pharmacists in Italy.

Participants to this breakout session should address the following questions:

- What has been the experience of professions in countries where CPD is mandatory – successes and problems? What has been the experience of professions in countries where CPD is voluntary – successes and problems? What are the advantages of voluntary CPD schemes versus mandatory systems?
- Are there any conditions which should be fulfilled for successful introduction of mandatory CPD?
- What has been the impact of introduction of mandatory CPD on the level of participation and quality of CPD?
- How were any existing barriers to CPD, particularly cost and constraints on the professional's time, impacted by the introduction of mandatory CPD?
- What has been the experience with CPD-linked revalidation schemes?
- In your experience, would you agree that there is a trend towards greater reliance on learning outcomes of CPD and competence assessments?
- How successful have been attempts to stimulate participation in CPD and enhance positive impact of CPD on clinical practice through greater attention to the interests and ambitions of the individual professional, for instance by introducing personal development plans?

▪ *Breakout session:* Impact of CPD on quality of care and patient safety

Quality of care and patient safety are broadly accepted to be at the very core of health professionals' CPD activities. However, explicit patient safety content in CPD is not as common. While the 2009 Council Recommendation[12] suggested embedding patient safety education in health professionals' CPD, the 2012 implementation report[13] found that only 15 countries actually had a formal requirement to include patient safety modules in one or more types of education. The present survey confirms that in a majority of countries it is not mandatory for health professionals to follow CPD activities specifically addressing patient safety; dentists and midwives were most likely to report mandatory CPD modules on patient safety (in 6 and 4 countries respectively). Around half of

[12] Council Recommendations of 9 June 2009 on patient safety, including the prevention and control of healthcare associated infections, OJ C 151 3/7/2009

[13] http://ec.europa.eu/health/patient_safety/docs/council_2009_report_en.pdf

all respondents for dentists, doctors, midwives and nurses and one third of pharmacists reported an increasing offer pertaining to activities on patient safety.

Survey respondents were also asked to indicate **national studies on the impact of CPD on professional practice**; however out of more than 150 respondents only 6 were able to share such studies.

Participants to this breakout session should address the following questions:

- How can we ensure that patient safety is adequately addressed by CPD activities?
- What are the advantages of creating specific patient safety activities and modules as opposed to including patient safety components in other CPD modules?
- Is mandating health professionals' participation in CPD on patient safety an effective way of improving patient safety and quality of care in practice?
- What other approaches might be employed? For instance, should patient safety content be required to obtain accreditation for a CPD activity?
- What is the impact of national standards and guidelines on quality of care on CPD?
- Considering the lack of studies on how CPD impacts on clinical practice and the absence of clear indicators that would allow measuring the impact of CPD on the competences or the performance of health professionals, are you aware of any relevant research or projects that would share more light on these issues?

▪ *Breakout session:* Barriers and incentives

Across the professions and countries surveyed, the **cost** of CPD and lack of **time** were uniformly quoted as the main barriers to health professionals' participation in CPD activities. Professionals felt they were not adequately financially supported and often had to cover the costs of CPD by themselves; in addition, they were generally expected to use their free time for CPD rather than being allowed to use working hours. Particularly nurses indicated that staff shortages are aggravating the issue, with employers even less likely to agree to absences. Individual funding and using personal time seemed to be more accepted by (self-employed) dentists.

The need to **travel long distances** to CPD events was also mentioned as a significant barrier, particularly in countries with large rural areas or in cases of small island countries such as Malta. Further barriers included lack of **relevant content** (for a profession or a specialty), lack of CPD of **sufficient quality**, **complexity** of the CPD system and **administrative red tape**.

Respondents also noted that there may be **lack of awareness about the importance of CPD** at the individual level, as well as **lack of motivation**, mainly because there is a perception that there are no immediate positive benefits derived from following CPD.

Incentives for health professionals' participation in CPD are employed to stimulate both mandatory and especially voluntary CPD but they remain relatively rare. Dentists are the most likely among the five professions to be offered incentives, in almost half of countries surveyed for voluntary CPD and in more than one third for mandatory CPD. The most frequent incentives are tax offsets (for the professional and less frequently also for the employer); they are employed more often for doctors and dentists than for nurses, midwives and pharmacists. Also reported were grants to support the cost of CPD activities and direct financial rewards upon completion of a CPD programme.

Participants to this breakout session should address the following questions:

- How could we make health professionals' CPD more affordable?
- How significant is the impact of the lack of specifically allocated (working) time for CPD?
- Do you see or expect this problem to become more serious in connection to existing or projected workforce shortages?
- What are the best ways of improving acceptance of the importance of CPD by an individual professional?
- Are you able to share any best practices of positive incentives (financial or otherwise) for participation in CPD?
- Are you aware of any studies on the impact of barriers and incentives on health professionals' CPD?

▪ *Breakout session:* Accreditation

Accreditation of CPD differs significantly across the countries and professions surveyed. **National CPD accreditation systems** are most likely to exist for doctors, followed by pharmacists, dentists, nurses and midwives. A number of countries mention use of the **UEMS EACCME® system for doctors**. The existence of an accreditation system is not always linked to mandatory CPD, and formal CPD activities are more than three times more likely subject to accreditation than informal activities. In most countries multiple organisations are involved in accreditation of CPD: professional associations and professional bodies with regulatory competence, Ministries of Health (particularly for nurses, midwives and pharmacists) and public accreditation agencies (for dentists and midwives). Accreditation is more often awarded to the CPD activity rather than to the provider, except for dentists, and criteria generally include compliance with professional guidelines, learning outcomes and activity duration. Fees are charged for accreditation in more than half of all cases, most likely for doctors and pharmacists and least likely for dentists.

Participants to this breakout session should address the following questions:

- How can accreditation contribute to quality assurance and independence of CPD?
- Is there a trend in terms of shifting from duration-based to outcome-based criteria in accreditation of CPD?
- How are accreditation bodies regulated at national level?
- Can we expect a greater role for private accreditation agencies and if so, how can we ensure that they are guided by the need for high standards of CPD rather than by commercial considerations?
- What are the advantages of accrediting CPD activities rather than providers?
- What are the benefits and challenges of European-level accreditation systems?
- Are there any activities for which international accreditation is more relevant (e.g. international events, eLearning)? How can it be ensured that European-level systems complement the responsibilities of national authorities and organisations?

▪ *Plenary:* European cooperation: cross-border dimensions of CPD

While the responsibility for the organisation of health systems and the education of health professionals rests at national level, there is also a cross-border dimension to health professionals' CPD. The cross-border dimension results from mobility of health professionals (based on the Directive on the mutual recognition of professional qualifications) and patients alike (based on the

2011 Directive on patients' rights in cross border healthcare as it clarifies the rights of patients seeking healthcare in another Member State). In their replies, the survey respondents indicated that **CPD activities followed in another EU Member State are often recognised**, either completely or partially; only one quarter of respondents indicated that this is not the case. This is surprising in view of the diversity of CPD systems and the absence of a formal recognition system of CPD activities at EU level.

Survey respondents envisioned a number of **modalities for cross-border cooperation on CPD**, from sharing best practices and problems faced to developing EU-level CPD modules (particularly eLearning and mLearning activities). Use of EU financing instruments, particularly structural funds was also mentioned. In addition, there was an expectation that European level discussion might stimulate strengthening national CPD structures. Finally, there was a lack of confidence that harmonisation of CPD is feasible due to the diversity of national traditions, and differences in CPD provision, accreditation and professional roles.

Participants to this breakout session should address the following questions:

- How can European cooperation provide added value in the area of health professionals' CPD and how can countries learn from each other?
- Specifically, how can it help Member States and professional organizations to achieve the objective of improving CPD to ensure high quality care and meet patient needs?
- Do you have experience of European instruments in the field of education that might be relevant to health professionals' CPD)?
- What lessons can be learned from other European initiatives in the field of accreditation (for instance UEMS-EACCME®, the Rome Group, European CME Forum)?
- Do you think that CPD needs to be better covered through those instruments or further considered in other European level initiatives?
- What is the basis and benefits for current cross-border recognition of CPD - international accreditation systems, bilateral agreements, taking decisions on a case-by-case basis?
- In the context of professional mobility, is shared understanding of CPD approaches and exchange of practice a desirable goal?