1. ABSTRACT

There is widespread recognition of the importance of continuous professional development (CPD) and life-long learning (LLL) of health professionals. CPD and LLL help to ensure that professional practice is up-to-date, contribute to improving patient outcomes and increase public confidence in the professions. National interpretations of CPD offer a rich scope of differing approaches and present opportunities for the identification of recommendations and best practices in the EU.

This study, funded under the EU Health Programme, comprises a unique mapping and review of continuous professional development and lifelong learning for doctors, nurses, dentists, midwives and pharmacists in the 28 member countries of the EU and EFTA countries. It describes the policy background to the topic, reviews available literature and illustrates the outcomes of a Europe-wide survey and expert workshop, as well as presenting an overview of EU and European-level initiatives on CPD. The study identifies policy recommendations to strengthen the exchange of cooperation and best practices at European level and highlighting the need to make efforts allowing all health professionals to undertake CPD, including addressing the main barriers identified, these being a lack of time and resources. The recommendations also call for more research into CPD and its relation to patient safety and quality of care.

2. EXECUTIVE SUMMARY

There is increasing policy interest in Continuous Professional Development (CPD) and Lifelong Learning (LLL) for Health Professionals in the EU. CPD and LLL help to ensure that professional practice is up-to-date, contribute to improving patient outcomes and increase public confidence in the professions. National interpretations of CPD offer a rich scope of differing approaches and present opportunities for the identification of recommendations and best practices in the EU.

Against this background, a 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 European Commission and funded by the EU Health Programme to carry out a 12 month study to review and map CPD and LLL for five health professions (doctors, nurses, dentists, midwives and pharmacists)[1] in the 31 countries of EU/EEA /EFTA. The study is the first to be developed jointly by dentists, doctors, nurses, midwives and pharmacists and to enable a multi-professional approach to discussing CPD.

Launched in October 2013, the study aims to:

- Provide an accurate, comprehensive and comparative account of CPD models, approaches and practices for health professionals, while also describing how these are structured and financed in the EU-28, and the EFTA/EEA countries; and,
- Facilitate a discussion between organisations 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.

At EU-level, the **role of CPD to help safeguard patient safety within the context of cross border mobility** has been addressed in several legal instruments: i.a. in the Council Recommendation on patient safety, including the prevention and control of healthcare associated infections, in Directive 2011/24/EU on patients' rights in cross-border healthcare, and most recently, in Directive 2013/55/EU amending Directive 2005/36/EC on the recognition of professional qualifications according to which "Member States shall ensure, by encouraging continuous professional development, that health professionals are able to update their knowledge.. to maintain safe and effective practice"

This study builds on a literature review establishing a context and glossary of key terminology; a pan-European survey among competent authorities and/or professional bodies at national level, addressing structure, governance, implementation, financial arrangements, content and future outlook. The methodology also includes research on European-level initiatives relating to CPD for health professionals. These findings were presented at a technical workshop attended by 60 experts from across Europe.

Study definition of CPD

> "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, 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."

CPD is an ethical obligation for all health professionals to ensure their professional practice is up-to-date and can contribute to improving patient outcomes and quality of care.

The study findings reaffirm the importance of CPD and LLL for health professionals, both in terms of professional and personal development.

CPD systems across Europe are highly complex and show different approaches across professions and countries. There is no evidence to suggest that one system is preferable to another.

There is considerable variance in CPD across countries and health professions, with mandatory and voluntary systems, and formal and informal delivery of CPD, sometimes existing side-by-side depending on country and profession. National approaches, e.g. as regards the (self-) regulation of a profession, are reflected in the governance and structures of CPD and LLL. The development of CPD policy is often a shared competence, with both professional organisations and ministries of health taking a primary role.

For the purposes of this study the definition of mandatory and voluntary CPD is:

- **CPD is mandatory** for all professionals practising in a country. The definition of mandatory CPD does not encompass cases where the CPD requirement is established by another body, for instance a professional association[1] or an employer.

- The definition of **voluntary CPD** is both the absence of mandatory requirements and includes cases where CPD is de-facto mandatory for a part of the profession (members of a professional association, professionals working within the statutory health system or other employer-related requirements) regardless of whether there are professional guidelines in place for the profession in question. A voluntary CPD framework may co-exist with a mandatory CPD system.

- **No formal CPD structures** exist and participation in CPD activities is left up to the individual professional. This is the least common situation recorded.

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[2] or it can be only a general obligation in which case it might be unenforceable. There are also examples of voluntary CPD frameworks, in which professional associations establish their own CPD requirements for their members resulting in a significant percentage of the profession participating in CPD.

MANDATORY CPD

The model of mandatory CPD requirements is the most common system across all professions. Marked differences exist between countries however: mandatory CPD requirements for all five professions were reported for only a third of all countries. The compliance and enforcement of mandatory CPD requirements varies in terms of actors involved, however professional bodies with regulatory competence play an important role for all five professions. The consequences of non-compliance also vary significantly, from the loss of the licence to practice over temporary suspension and various penalties to no automatic consequences at all.

VOLUNTARY CPD

Around half of all survey respondents indicated that there is a voluntary CPD framework in place in their country. Its formal structures and governance are often less prescriptive than for mandatory CPD requirements. Tools such as positive incentives are more frequently used. Enforcement varies from monitoring by professional bodies with a regulatory competence to no formal monitoring structures. Consequences of non-compliance with voluntary CPD frameworks, if any, are usually less restrictive.

In very few cases, the findings show that there are no formal CPD structures in place for a certain profession, meaning that there is no national system or guidance for professionals. In this case, individual professional ethics and interests, and potentially employers' indications, are the drivers for following CPD activities.

[1] when membership in the professional association is not mandatory for all professionals

CONTENT AND DELIVERY OF CPD

For the majority of professions, professional bodies and scientific societies are reported to be the most frequent providers of CPD activities. For doctors and especially for pharmacists, the private sector often plays an important role in providing CPD. The development of content of CPD activities largely corresponds to the bodies representing the providers of CPD activities. Medical specialty or employers often require health professionals to follow prescribed content of CPD activities. The most popular form of delivery of CPD was reported to be in the form of conferences, symposia, lectures or seminars. ELearning or web-based learning was ranked as the third most frequent form of delivery.

ACCREDITATION

The accreditation of CPD activities is more common across Europe than the accreditation of CPD providers. There are still significant differences as regards the details of the accreditation systems' functioning. Accreditation is mostly, but not always, obligatory, in particular for formal CPD activities, and in systems with mandatory CPD requirements. Also the competence for accreditation varies, with many systems sharing the competence among several bodies, while professional organisations and professional bodies with regulatory competence are the most frequent accreditors. The most frequent criteria for accreditation are the duration of an activity, compliance with professional guidelines and learning outcomes. Fees are charged according to the majority of respondents, with wide variations as to the amount.

FINANCIAL FACTORS

For all professions, the most frequent form of funding of CPD activities is through the participating professionals' fees. Depending on the profession, professional bodies, employers or the private sector are also important sources of funding. Guidelines or codes of conduct are in place to ensure the transparency and independence of CPD for more than half of all survey respondents from 31 countries. Often these are embedded in professional bodies' codes. There are also differing rules as regards following CPD activities in paid working time.

It is understood that CPD can contribute to patient safety, however so far there is limited research on this relationship. CPD is only one of many contributing factors to achieve a culture of patient safety.

CPD is seen as a tool to improve patient safety, though the concept must be understood as encompassing many factors beyond CPD. There is limited research available addressing the relationship.
While there are activities on patient safety available for all professions, it is not mandatory for professionals to follow them in a majority of cases. However, the offer of CPD activities on patient safety is reported to be increasing in most countries.

Across all countries, professionals report the burden of costs and the lack of time as the main barriers to accessing CPD activities.

There is broad consensus that the costs of accessing CPD activities, most often borne by the professionals themselves, as well as the time which must be invested in CPD activities, are seen as barriers. Contextual factors, such as the availability of financial relief relating to the cost of CPD or the extent to which CPD can be followed within working time differ substantially, sometimes even within a profession in one country, due to factors such as practice setting and employer. Other barriers reported less frequently include the lack of motivation or incentives, as well as technical barriers to accessing CPD activities, such as a scarcity of activities or geographical distance. In a smaller number of cases, but particularly for dentists, no barriers are perceived.

European cooperation to exchange experience and good practices is largely welcomed as providing an added value to strengthening national CPD systems.

There is general agreement that European cooperation can provide added value through the exchange of good practice, also to benefit national systems and to enhance transparency within the context of cross-border mobility. Cooperation between countries on CPD and LLL already takes place, as demonstrated by the significant volume of cross-border recognition of CPD activities, notwithstanding that the modalities of recognition differ between countries, professions and activities. European initiatives on CPD and LLL, also beyond the health sector, are shown to have a varying degree of up-take in and impact on national CPD

systems in supporting cross-border cooperation. Financial support mechanisms at EU-level can facilitate CPD activities, for example through the development of common training modules or research on the impact of educational approaches to CPD and their effect on quality of care. Existing EU-level initiatives to improve transparency between national systems of education and training indicate that greater transparency may also be achievable in the context of CPD, with the objective of enhancing the cross-border dimension of CPD. European cooperation is also suggested to support the exchange of good practice. The differences between national CPD systems however also necessitate that EU-level initiatives are voluntary in nature.

Future research should expose links between CPD and patient outcomes and to review developments to establish trends.

There is a relative dearth of research of the impact of CPD on patient safety and care outcomes, and on clinical and professional practice. More research on the links between different types of CPD and practice outcomes is therefore recommended. Also, the snapshot exercise delivered in the present study could be followed upin future, to establish trends and explore questions resulting from the research, such as the preferred areas for European cooperation.

Recommendations

The full report sets out 22 recommendations to help strengthen CPD in Member States and promote European cooperation in five areas:

On **CPD structures and trends**, the recommendations highlight the need for all stakeholders involved, including competent authorities and employers, to recognise the importance of CPD and to enable all health professionals to undertake CPD suitable to their needs and interests.

Looking at **barriers and incentives to following CPD**, the need for systemic and organisational support to professionals, in terms of allocating time for CPD in workforce and staff planning and in ensuring costs of CPD are not prohibitive, is identified as a shared responsibility, in which employers, professional organisations and the ministries of health have a role to play, alongside the professional. It is also recommended to make use of flexible learning tools and ensure CPD is relevant to health professionals' daily practice, so as to improve access and motivation.

On the relation between **patient safety and CPD**, it is recommended that patient safety must be enshrined in professionals' education and training throughout and supported by the workplace environment. It is also beneficial to specifically address patient safety issues in specific CPD activities.

In terms of **accreditation systems**, the recommendations suggest the role of health professionals in the accreditation of CPD is key. It is also proposed to evolve accreditation systems to be increasingly outcome-based.

Concerning the **role of European cooperation for CPD,:** facilitating policy discussion, the exchange of best practice and experiences through EU-level structures is recommended, as is the funding of research, e.g. into the relationship between CPD and quality of care or the opportunities for voluntary EU-level frameworks to support cross-border recognition of CPD.

Key Actions

- Efforts must be made to ensure that health professionals in all Member States are able to undertake CPD activities in accordance with Member States' obligation under the revised Directive on the recognition of professional qualifications.
- Member States should adopt measures to address the main obstacles to undertaking CPD: time, human resources and cost.
- Further research should be done on the impact and systems of health professional CPD, in particular as regards the relation between CPD and patient safety, quality of care and patient outcomes.
- Any EU recommendations on health workforce planning and forecasting should take CPD into account to avoid workforce shortages preventing professionals from undertaking CPD.

- The European Commission should make the information on health professionals' CPD collected in the context of the Directive on the recognition of professional qualifications available to the public. The European Commission should utilise existing platforms for the exchange of best practice on CPD, i.e. the Group of Coordinators and the European Commission working group on EU health workforce. Professional organisations should be involved.