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CPD Groups: A Vehicle for Staying on the HPC Registration Road

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Abstract

This evaluation describes one work-based Continuing Professional Development group of six occupational therapy staff. The evaluation aimed to identify activities completed by the group and evaluate the group's effectiveness in meeting the Health Professional Council standards for CPD using a postal survey questionnaire. The group enabled participants to maintain a record of their CPD, to engage in a mixture of learning activities, and improve participants' practice, service delivery and outcomes for service users and carers. The CPD group enabled participants to meet four of the five HPC standards for CPD, indicating that work based CPD groups offer the potential to overcome many of the previously identified barriers to CPD in an effective way.

Key words: Continuing professional development, lifelong learning, clinical governance, occupational therapy, health professions council, reflection.

Introduction

This practice evaluation considers the impact of a work-based continuing professional development (CPD) group on the clinical practice, service delivery and outcomes for service users and carers of a group of occupational therapists working across different multi-disciplinary teams within a mental health service for older people. The CPD group's ability to meet the Health Professions Council's (HPC) rules and regulations is considered in the context of the many barriers to CPD. The opportunities taken, and those missed, by the group are considered, with recommendations made for future practice and research.

Background

In 1998, the White Paper 'A First Class Service' aimed to improve the quality of clinical care within the National Health Service (NHS) through the processes of clinical governance, lifelong learning and professional self-regulation (Department of Health 1998). Clinical governance provides health professionals with a framework for improvement of clinical practice. This includes clinical risk management, clinical audit, research and development and continuing professional development (CPD), all based on the best available evidence (Mc Sherry and Pearce 2002, Department of Health 1999). Clinical governance is supported by a culture that values lifelong learning to improve quality by ensuring staff have current skills and knowledge for delivering high quality care (Swage 2004).

The Department of Health defined CPD as 'a process of lifelong learning for all individuals and teams which meets the needs of patients and delivers the health outcomes and healthcare priorities of the NHS and which enables professionals to expand and fulfil their potential' (Department of

Health 1998 p43). While lifelong learning is about a cultural shift in the NHS, CPD requires the individual to take responsibility for this learning by systematically analysing their development needs; identification and use of appropriate methods to meet these needs; and regular review of achievements against a set of standards or goals (Swage 2004). The General Medical Council (GMC), Nursing and Midwifery Council (NMC) and HPC have all developed processes to revalidate and renew registration based on evidence of lifelong learning and CPD. Professional self-regulation ensures that all staff are fit to practice within their areas of speciality (Warne 2002). Within this framework, the responsibility for quality and control lies both with the individual and the organisation (White 2001).

The Health Professions Council was formed in 2001 to set standards of professional training, performance and conduct for allied health professions, including occupational therapists, art therapists, dieticians and physiotherapists (Department of Health 2001). From July 2006 allied health professionals within the HPC have been required to undertake CPD and keep a record of it in order to demonstrate their continuing fitness to practice and maintain their registration (HPC 2005). For occupational therapists, the College of Occupational Therapists (COT) has clearly identified the professional responsibility of all occupational therapy personnel to maintain and develop their professional competence by undertaking CPD, maintaining a portfolio of that CPD, completing an annual personal development plan and ensuring that all practice is based on the best available evidence (COT 2000). This includes occupational therapists of all grades, associate members such as technical instructors, managers and academic staff (COT 2002, COT 2004).

Unfortunately, there are practical difficulties to engaging in CPD. Barriers to the completion of CPD activities for a range of health professionals include inadequate time and resources, management and leadership styles, personal feelings towards CPD, the need for a cultural shift relating to CPD, and the expectation to complete all work activities missed during the time taken for CPD (Ruston et al 2002, Saidi and Weindling 2003, Wiks and Boniface 2004). Restructuring of Trusts and prioritisation of tasks were also identified (Spalding et al 2000) and will continue to pose a challenge in the current climate of the NHS.

CPD is most effective where there is sufficient workforce planning, an effective method of appraisal, and leadership skilled in the development of staff (Pringle and Moore 2001). Occupational therapists capacity to meet the published HPC rules and standards for CPD is dependent on their desire for personal and professional development, their ability to critically reflect on practice and their commitment to learning (Alsop 2002). To do this, professionals need to identify creative and innovative learning opportunities in order to overcome the barriers to CPD.

One such opportunity is participation in a CPD group. In December 2002 an occupational therapy service for older people with mental health problems established a CPD group. Group members, including the author, all worked in multi-disciplinary teams across the service in the areas of in-patient care, day hospital, a community mental health team and a specialist service to nursing and residential homes in the locality. The aims of the group were to share learning to make the most of scarce training resources, develop professionally, and develop our portfolios as a record of our CPD. The

group was established around the time that the HPC were planning mandatory CPD so there was also a high level of anxiety amongst group members about doing enough CPD to maintain registration.

The CPD meetings were held for two hours one afternoon each month, with an annual day set aside for more comprehensive sharing of learning. The content of the sessions was initially flexible to respond to practitioners changing needs (Ruston et al 2002). Early topics covered included portfolio development, evidence based practice and service evaluation. However the early sessions were not well structured and sometimes lacked focus. As the group developed it became more practical to annually select topics of interest where development was needed. Individual members suggested topics they were interested in learning more about, and also areas where they held expertise that could be passed on to other group members. We then agreed by consensus which topics we would cover and when, and who would lead a workshop on each topic. This made use of both occupational therapy and assistant staff expertise and reduced the risk of the group becoming a 'teaching' session dominated by one or two members. The annual all-day session was planned to cover feedback on training that each person had participated in during the year. For this session we each ran one or two hour-long workshops based on a course we had attended.

Although the group had been meeting for a number of years, no formal evaluation of the effectiveness of the group in meeting the needs of the participants had been completed. This led to the development of a practice evaluation to determine the group's benefits.

This evaluation aimed to

1. Identify which CPD activities were engaged in by the group and their value to participants.

2. Evaluate the CPD group's effectiveness in meeting the HPC standards for CPD.

Study Design and Methods

Rationale for Methods Used

Survey questionnaires are an appropriate method to monitor standards (Edwards and Talbot 1999), in this case the HPC standards for CPD. They also enable information gathering where resources for evaluation are limited (Hicks 2004). A questionnaire was designed (Plastow and Boyes 2006) as no measurements or tools were identified that evaluate the effects of CPD (Boynton and Greenhalgh 2004). Descriptive analysis of the data was used as no previous research has been completed on participation in a CPD group or on CPD in the occupational therapy literature (Brink and Woods 1998).

Evaluation Sample

A purposive sample of the six occupational therapy personnel currently working in the service and attending the CPD group was selected (Bowling 1997). This included a Head III, Senior I, two Senior II occupational therapists as well as two technical instructors level I and level III. The service manager, who did not participate in the group, received a different questionnaire. The service manager was included as they complete the annual appraisals, provided supervision to some group members, and had approved the establishment of the CPD group. All participants consented to the study, however only five of the six participants plus the service manager returned their questionnaires.

Data Collection

The survey questionnaire was sent to all participants after receipt of a consent form. The questionnaire was designed as a more objective method of collecting information on participants' knowledge, beliefs and attitudes towards the CPD group. Open and closed questions were used, based on the literature reviewed and the areas of CPD proposed by the HPC. The key phases of questionnaire design proposed by Daykin and Stephenson (2002) were used to ensure the questionnaire was well designed and fit for purpose, and was coded to protect the identity of participants. The questionnaire was initially reviewed by the Trust's research governance committee and was subsequently piloted by a group of occupational therapists at a different Trust in order to improve the quality of the survey (Saris et al 2004). Only minor changes were made to the structure of the questionnaire based on this pilot.

Data Analysis

The quantitative data gathered from the closed questions was analysed as descriptive data using Microsoft Excel due to the small sample size (Daly and Bourke 2000). Qualitative data from the open questions was inductively analysed using a three-pronged strategy of data extraction, formulation of themes of meaning and comparison to the original data (Miles and Huberman 1994).

Ethical Issues

Ethical approval for this evaluation was gained from the author's university research governance group and the Trust's research governance committee. Local research ethics committee approval was not required for this project.

Results

Standard 1: Registrants must maintain a continuous, up to date and accurate record of their CPD activities .

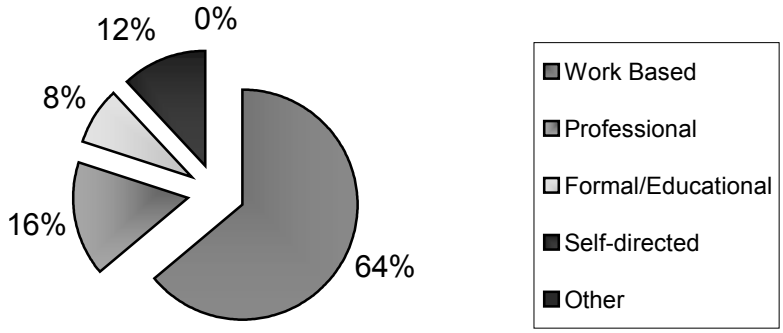
The most commonly reported method of maintaining a record of CPD is the portfolio. Although all group members kept a portfolio, only two participants recorded group participation in their portfolios, two kept some information

and one participant indicated they kept no record of the CPD in their portfolio.

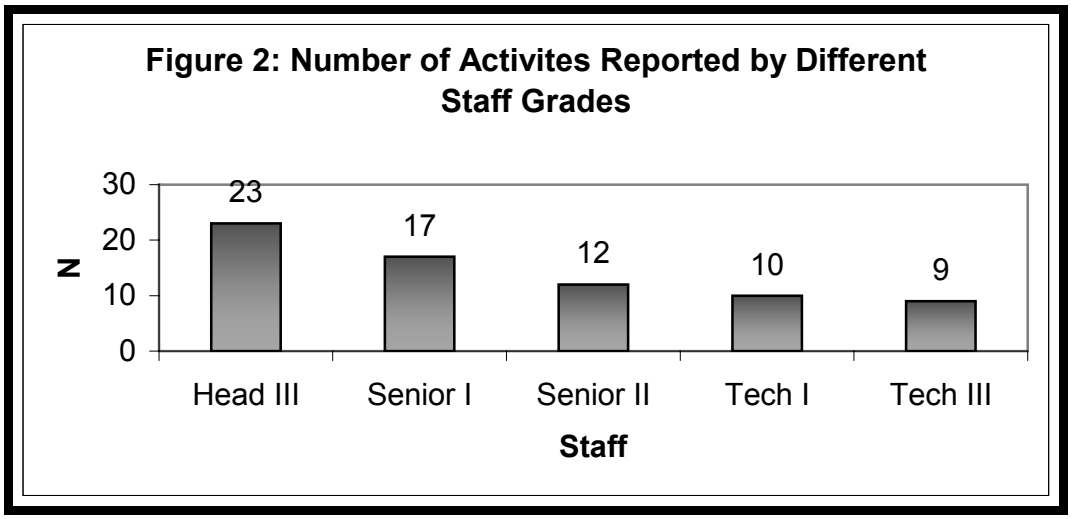
Standard 2: A registrant must demonstrate that their CPD activities are a mixture of learning activities relevant to current or future practice.

A list of 27 CPD activities which could be completed as part of a group was compiled based on the HPC list of suggested CPD activities. The mean number of activities reported by each participant was 14. This included four of the five types of CPD activity identified by the HPC (Figure 1). Work base learning activities occurred most of the time (64%) and included discussing case studies, reflecting on practice, clinical audit, receiving coaching from others, discussion with colleagues, completing self-assessment questionnaires, in-service training and developing protocols and guidelines for practice. Professional activities comprissed 16% of the time included maintaining and developing professional skills and organising and running the CPD group session. Less frequent were formal/educational activities like undertaking research and self directed activities like reading books.

Figure 1: Learning Areas of Reported CPD Group Activities



Interestingly different participants recalled participating in different activities. The senior occupational therapists reported significantly more CPD activities than the two occupational therapy assistants. This may indicate that different members are gaining different benefits from the group or that the senior staff were making more of the CPD opportunities available within the group (Figure 2). Overall, group participants were generally engaging in a range of different CPD activities.



Standard 3: A registrant must seek to ensure that their CPD has contributed to the quality of their practice and service delivery.

All participants agreed that the CPD activities they engaged in as part of the CPD group contributed to both the quality of their practice and service delivery. Examples given by participants included increased awareness of medication used in old age psychiatry, sharing knowledge of practice, audit, increasing awareness of current research, and improved paperwork/record keeping.

Standard 4: A registrant must seek to ensure that their CPD benefits the service user.

Four participants agreed that participation in the group benefited service users, for example identifying the side effects of medications, and increased awareness, such as the need for people with dementia to be given an opportunity to share their feelings about their diagnosis. Evaluation with service users or practice audit needs to be completed to support these views.

Standard 5: A registrant must present a written profile containing evidence of their CPD upon request.

Although all participants reported having a portfolio, they have not taken full advantage of recording their learning. Only two examples of written evidence were kept by a majority of participants: information leaflets and reflections on learning. Only two participants agreed they did include the CPD group in their annual development plan.

Discussion

Making the Most of Opportunities Available: Implications for Practice.

Successful aspects of the group included having a regular time set aside for CPD each month, limiting meeting times to two hours, sharing responsibility for planning and delivery of session content, and the annual

sharing day. This reminded participants of that year's training and provided an additional opportunity to reflect on how the training had influenced their practice. Aspects that were less successful were initially not planning the sessions in advance, lack of integration with supervision and personal development plans, managing the difference academic experiences of team members, and not having a robust system in place for recording of the group's discussions each month (although we did keep a resource file). Evaluation of this CPD group suggests that the group is making a contribution to the lifelong learning and continuing professional development of all the staff members involved. It is also missing some of the opportunities for learning and development.

Opportunities Taken

The CPD group has overcome a number of barriers to CPD by engaging in a range of CPD activities for the relatively small investment of time of two hours per month plus one full day per year. It has also maximised scarce formal education resources by providing participants with an opportunity to share formal events with others in the service. Two group members were pursuing higher education qualifications – a degree in dementia care and masters degree in professional health studies. The group also led to the dissemination of knowledge and skills gained by these members in higher education, such as evidence based practice, considering ethical issues in dementia care, and selection and testing of validated outcomes measures to evaluate practice.

Another potential barrier to CPD identified in the literature was the need for cultural change. The value placed on the group by its members demonstrated by the continuation of the group over a number of years; their active engagement in annual personal development reviews; and the development of portfolios by participants have all contributed to a culture of learning and development.

Although it was not an issue when the group was established, by the time of this evaluation service modernisation had a direct impact on all participants. Although using the CPD time to address modernisation issues and evaluate performance for Health Commission reviews was greeted negatively by the group members, group participation reduced the impact of modernisation on participants' professional development. Within this environment of change, workforce planning, leadership and management support, have meant that CPD has continued to be effective within this staff group.

The final opportunity taken is the balancing of personal learning needs with the learning needs of the group. This is demonstrated through the variation in activities by the group members. The group consists of a broad range of staff members, including those who are not trained as occupational therapists. All staff have been given the same developmental opportunities and have also learnt to work together more effectively as an occupational therapy team – one of the key values of the group highlighted by participants.

Opportunities Missed

CPD is a systematic process of analysing learning needs, using appropriate methods to meet these needs and reviewing achievement against a set of goals (Swage 2004). A missed opportunity was the lack of a link between the well-established processes of annual review where work-based learning needs were discussed at length at a meeting with supervisors resulting in an annual personal development plan, regular supervision, and the activities of the group. Integration of the CPD group into this process could improve in two ways. Firstly, in considering whether they have met the previous year's personal development goals participants could include relevant activities within the CPD group. Secondly, in identifying goals for the forthcoming year participants could plan to deliver relevant group sessions on that topic.

The lack of skill, competence and confidence of occupational therapy staff using research literature is well documented. Although the group have given some examples of engaging in the three stages of research use – participation, utilisation, evidence-based practice (Tse et al 2004), there appears to be little integration of these experiences.

The final and perhaps most important missed opportunity is the recording of CPD group experiences in participant's portfolios. The HPC rules and standards make it clear that the recording of development activities is as important as participation in them when engaging in CPD. The maintenance of these records is not only important to maintain registration, but also gives participants an opportunity to reflect on their learning experiences and identify an action plan for using learning in practice.

Limitations

There are a number of limitations for this evaluation. Despite a good range of information being gathered, the data collected may have been richer and more descriptive in content had semi-structured interviews been used. The evaluation also utilised a small sample group, given that survey data was gathered. Although this particular CPD group was the interest of the researcher, the small sample group limits the generalisibility of this evaluation. The proximity of the researcher and the researcher's previous relationship with the participants may have also biased the results, although the author had not worked with the participants for over 12 months.

Conclusion

Continuing professional development is now unavoidable for all health professionals, including occupational therapists, who wish to remain registered to practice. The requirement to meet the standards for continuing professional development within the context of clinical governance, reform of the public sector, and professional codes of conduct means that all occupational therapists will need to make effective use of the time they have available for life-long learning. Although the Health Professions Council has identified a range of learning opportunities available, the most accessible are those that are work-based.

This study aimed to evaluate one work-based learning opportunity not mentioned by the HPC, the CPD group. This evaluation suggests that occupational therapists can engage in a wide variety of CPD activities as a group, enabling them to meet the majority of the HPC's rules and standards. Where some of the standards have not been met, there are opportunities for improvement that will enable the meeting of these standards. The CPD group potentially offers valuable opportunities to develop clinical practice, gain new knowledge, improve service delivery and record personal development. This can enable mental health allied health professionals to continually develop their clinical skills and practice and to remain on the registration road.

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