The importance of continuing professional development

Profession

This essay aims to discuss the importance of Continuing Professional Development (CPD) within a NationalHealthService (NHS) medical imaging department; and how it contributes to delivering high quality patient-centred care. It will include any associated advantages and/or disadvantages to the NHS and imaging department; and discuss the impact of compulsory CPD associated with management and service delivery. Finally, radiography specific examples of CPD currently documented within the NHS will we stated with suggestions for increased uptake of CPD within imaging departments.

CPD is described by the Health Professionals Council (HPC) as ‘ a range of learning activities through which individuals can maintain and develop throughout their careers, to ensure that they retain a capacity to practice legally, safely and effectively within an evolving scope of practice’ (HPC, 2006: 1). All radiographers must be registered by the HPC in order to practice in the United Kingdom; ensuring regulation and compliance with prescribed standards of practice. This therefore provides public protection.

In 2005 the HPC made CPD a mandatory requirement for all health professionals in order to remain registered, or if renewing registration (SCoR, 2008: 5). Registrants are required to keep accurate, continuous and up-to-date CPD records of activities. This includes professionals in full or part-time work, in management, research oreducation(HPC, 2006: 3). The activities should be varied and include for example, work based learning, professional activity, formal education and self directed learning; which should have relevance to current or future practice (HPC, 2006: 2).

The practitioner must aim to show that the quality of their practice, service delivery and service user have benefited as a result of the CPD. In addition to patients, ‘ service user’ also encompasses clients, department-team and students (HPC, 2006: 4). To ensure compliance with HPC standards, a random selection of registrants are audited with their CPD profile being submitted and reviewed. The practitioners profile must demonstrate a representative sample of activities, with a minimum of twelve recorded pieces pning the previous two years; documenting professional development. HPC, 2006: 3).

The process of CPD requires the practitioner to review their practice regularly, in order to identifying learning requirements (SCoR, 2008: 1). After performance of the CPD activity, an evaluation and written statement summarises its impact, quality and value to future practice (SCoR, 2008: 2). Although some CPD learning activities will occur spontaneously it may also be done through discussion with a manager (SCoR, 2008: 4).

This continuous process maintains and enhances expertise, knowledge and competence, both formally and informally; beyond initial training (Jones and Jenkins, 2007: 7). It allows ongoing development through life-long learning and ensures the practitioner achieves their full potential, helping provide a high quality patient-centred service, based on up to date evidence (RCR, 2007: 10). The advancement ofdiagnosticimaging and the demand for imaging services in the NHS has significantly affected the role of the radiographer (Smith and Reeves, 2010: 1).

Understanding that radiographer’s initial training is not sufficient for the duration of theircareer, coupled with many significant government developments, has emphasised the need for CPD; with associated advantages and disadvantages to the NHS and imaging department (Jones and Jenkins, 2007: 7). French and Dowds (2008: 193), suggests that through CPD, professionals can achieve professional and personal growth, acquire, develop and improve skills required for new roles and responsibilities.

In support of this Lee (2010: 4) suggests that CPD related to self-confidence, improved ability to problem solve, with a greater understanding of local and national organisational needs. However, it was consistently found that new skills and knowledge deriving from CPD activities could not be utilised, due to trust protocols and policies (Lee, 2010: 3). This suggests that when CPD is harnessed and applied effectively it is advantageous to both the practitioner, imaging department and NHS, yet the organisation can restrict its application, therefore not utilising its potential benefits (French and Dowds, 2008: 195).

High-quality, cost effective patient-centred care is central to the modernisation of health service. To achieve this government policy is focussing on multi-professional working, new roles and increased flexibility throughout the workforce (RCR, 2006: 6). Therefore, a practitioner’s ability to extend and adapt their roles within this rapidly changingenvironmentis central to the NHS’s and imaging departments development (Jones and Jenkins, 2007: 7). Gould et al (2007: 27) suggests reduced patient mortality

has been strongly correlated with CPD; and patient outcomes are improved with multi-professional team-working.

However Gibbs (2011: 3) suggests that tensions may occur with implementation of a multi-professional approach to working, resulting from practitioners preferring to stay within familiar professional boundaries. Although this suggests there are significant patient benefits to role adaption as a result of CPD, It may only be utilised if practitioners have the willingness andmotivationto develop their roles (Gould et al, 2007: 31). With role adaptation initiatives however, there are risks of reduced standards of care; with practitioners needing to remain aware of their scope of practice andaccountability(RCR, 2006: 10).

To ensure clinical governance standards are maintained; audits should be used to check performance and compliance against agreed standards (RCR, 2006: 10). An essential element of CPD is being able to reflect and learn from experiences, including service failures (SCoR, 2005: 1). Understanding why something has happened and implementing a positive change in practice, as a result, will contribute to continual improvement in services systems (RCR, 2006: 10).

Gibbs (2011: 2) suggests that CPD helps the NHS comply with local and national strategies, in addition to quality monitoring and good governance. This helps provide patient safety whilst minimising medical negligence penalties; in 2008-2009 alone the claims against the NHS were ? 769 million (Shekar, 2010: 31). The Agenda for Change resulted from a workforce crisis, resulting from low staff morale, lack of professional progression and

unchallenging careers. The importance of lifelong learning was recognised as being pivotal in addressing these issues (Jones and Jenkins, 2007: 10).

It introduced a four-tier structure, incorporating a competency based system for continual learning, the Knowledge and Skills Framework (KSF); this provided fair CPD access to all (Gould et al, 2007: 27). Within the imaging department it promoted, encouraged and expedited role development and generated new radiographic roles (Woodford, 2005: 321). It was highlighted that in order to meet service needs and radiographer aspirations role development was necessary (Woodford, 2005: 320).

It provided improvements in equal opportunities, career development with improved CPD opportunities; and consequently increased morale and retention rates (DH, 2004: 2). However, Williamson and Mundy (2009: 46) suggest that if role development and career aspirations did not materialise the investment in recruitment, retention and improved morale would be wasted. As a consequence a depleted workforce and lack of service provision, could potentially compromise patient safety (Gibbs, 2011: 2).

An annual appraisal and personal development plan is a requisite of the KSF. This identifies individual training requirements and formulation of a CPD plan; highlighting targets and objectives that meet the organisation needs and practitioners career aspirations; followed by performance review (Gould et al, 2007: 27). This cultivates effective training and development throughout all stages of an individual’s career, in addition to highlighting areas for development within the department team (Gould et al, 2007: 28).

Jones and Jenkins (2007: 7) suggest that an annual appraisal can help structure and guide an individual CPD, creating a better standard of service. Additionally, Gould et al. (2007: 29) found that poorly planned CPD could have little to do with the appraisal, service or staff development (Woodford, 2005: 324). This indicates efficiently planned CPD and personal development plan can help develop the inherent potential in staff, improving knowledge in best practice whilst promoting a greater degree of autonomy (Jones and Jenkins, 2007: 10).

However, to achieve this clearcommunicationwith the manager ensuring joint agreement and appropriateness of training requirements is necessary (Jones and Jenkins, 2007: 11). Manager responsibilities include the development of the workforce for good service delivery, with identification and provision of appropriate education and training. This ensures practitioner roles are supported, safe to practice and suitable for the purpose (RCR, 2005: 8). Compulsory CPD does not guarantee that learning occurs in practitioners who lack motivation; compliance with regulations may be their only impetus (Jones and Jenkins, 2007: 9).

Barriers may be affecting participation, for example, the individual may feel a lack of choice in determining particular learning needs with the manager dictating the activity; or personal conflict with the idea that adult learning should be self-motivated and a self-directed process (Lee, 2010: 3). French and Dowds (2008: 194) highlight a number of other barriers to CPD participation, including time constraints, the CPD being of no professional

relevance, inadequate finances, not enough staff to cover and a lack managerial encouragement.

In support of this Gould et al (2007: 606) identified barriers to CPD in particular groups, including those nearing retirement, staff working only at weekends or nights and part-time staff. This indicates the need for managers to understand the factors that inhibit and facilitate the practitioner's ability to effectively engage in CPD; therefore ensuring the staffs' continued HPC compliance and retention of registration (SCoR, 2009: 3). Although motivation towards CPD is pivotal it needs to work in association with protected study time, opportunities and recognition that CPD is integral to patient care (Jones and Jenkins, 2007: 11).

With financial constraints managers can find it challenging to provide sufficient opportunities and resources for practitioners to undertake CPD (French and Dowds, 2008: 195). Withmoneyand time being invested the input must be justified. Gibbs (2011: 2) suggests that informal learning cannot be assessed unlike formal learning; and it is hard to show how either will be applied to practice. However, nurses in a study by Gould et al (2007: 606) felt that work based-learning helped to keep staff motivated, interested and had more impact on patient care.

This suggests that although informal learning is a subjective process, there are perceived benefits; furthermore, reflecting onpersonal experiencewill increase proficiency (French and Dowds, 2008: 194). If funding is insufficient, managers may see CPD as an extravagance that cannot be afforded (Gibbs, 2011: 2). With the substantial costs of replacing an NHS professional, it

seems logical for employers tofinanceCPD, therefore securing a motivated and proactive workforce, whilst safeguarding service delivery (French and Dowds, 2008: 195).

Compulsory CPD required by the HPC has the advantage of ensuring competence in registered practitioners, therefore providing public protection and confidence in the service (Gibbs, 2011: 2). As radiographers are required to base their CPD on recent research, patients should expect to be diagnosed and treated with currently approved approaches (Gibbs, 2011: 3). However, it is difficult to establish if there is improved patient outcome directly resulting from CPD, as many other variables could have an affect (French and Dowds, 2008: 194).

This would suggest that compulsory CPD has the potential to provide better quality patient-centred service, however if insufficient audit and research to evaluate the practice is not in place, there is no evidence to support its influence on service provision (SCoR, 2010: 4). Compulsory CPD also has a positive impact on the range of activities and quantity of CPD undertaken (French and Dowds, 2008: 192). This affords further opportunities within the profession and is integral to the extension of professional roles and boundaries; complying with current drives for service improvement (Williamson and Mundy, 2009: 41).

Woodford (2005: 321) states ‘ double barium contrast enema was one example of role extension benefitting service to patients by reducing long waiting lists and numbers of unreported examinations’. The evaluated studies established better service provision, for example patient waiting

times; freeing up radiologists time to perform other duties, and cost effectiveness (Woodford, 2005: 325). However, Smith and Reeves (2010: 113) state that there were barriers to adopting radiographic role-extension from radiologists, who hindered the radiographer’s progression.

This suggests that intent from radiographers and government to achieve improved patient services can be impeded without the support and co-operation of radiologists who are central to the radiographic team and necessary to implement the changes (Woodford, 2005: 325). The financial challenges affecting the NHS have reduced CPD opportunities (Gibbs, 2011: 3). To help increase local uptake, innovative and cost effective approaches can be fostered in a supportive learning environment within the imaging department (French and Dowds, 2008: 195).

Gibbs (2011: 4) suggest that the least costly CPD options are often overlooked, with poorly resourced departments often underutilising these opportunities. Work-based learning (WBL) for example journal clubs, in-service education programmes staff/student supervision, or taking time to reflective on practice (HPC, 2009: 6), provides an effective, flexible way of enhancing practice within the workplace: and also enables easier staff release (Gibbs, 2011: 3).

It is important to ensure that the activities are linked to evidence-based practice for recognition ofacademiclearning (Gibbs, 2011: 4). However, although these activities may have reduced monetary implications they still use time (Jones and Jenkins, 2007: 11). Hardacre and Schneider (2007: 12) suggest that WBL offers the benefits of familiar staff surroundings, provision

of a staff-support network and programmes that are designed around staff and the organisation; which helps meet their needs.

French and Dowds (2008: 194) suggest that professional practice showed positive change as a result of hands-on training. Although the convenience of WBL is apparent, it could restrict radiographers CPD opportunities in higher education; with employers preferring the WBL as it revolves around the organisations work, rather than for professional gain; this could inhibit the growth of the practitioner and service development (Munro, 2008: 954).

Specialist practitioners could find suitable CPD courses hard to access locally; with the expense of providing for small groups. However, the KSF could be used to identify similar issues within other trusts, by collaborating when commissioning, costs could be reduced due to the increased number of participants (Gould et al, 2007: 30). Communicating CPD needs between other trusts and providers of education could be a cost effective approach to CPD opportunities, and could prevent duplication of similar courses locally (Gibbs, 2011: 2).

Utilising technologies more extensively provides a diverse range of CPD activities such as webcasts, podcasts, on-line packages, CORe-learning programmes, video conferencing and discussion boards. (Gibbs, 2011: 4). This offers a flexible approach to updating skills and knowledge, with post-evaluation being quickly and easily accessible. However it is dependent on computer skills, educational level and internet access (French and Dowds, 2008: 193).