Allied health professions project: 
Demonstrating competence through continuing professional development [CPD]

Final report

August 2003
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Abbreviations used in the document

AHPs - Allied health professions
AHPF - Allied Health Professions Forum
CPD - Continuing professional development
DoH - Department of Health
HEIs - Higher education institutions
HPC - Health Professions Council
ILT - Institute for Learning and Teaching
KSF - Knowledge & Skills Framework
WDCs - Workforce Development Confederations

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Executive summary
The allied health profession [AHP] project on demonstrating competence through continuing professional development [CPD] involved all the professions currently regulated by the Health Professions Council [HPC] (fourteen in total). It was funded by the Department of Health for England, although was UK-wide in its coverage and perspective.

The project’s approach was designed to fit with broad quality agendas, including clinical governance. A keenness to influence how the HPC introduces re-registration requirements in the future formed a major impetus to activity. More broadly, the project aimed to develop the professions’ commitment to, and capacity for, a planned, structured, evaluated approach to CPD focused on

• What are the outcomes of learning?
• How are these applied to professional practice?
• What are the benefits of this (particularly in terms of enhancing patient/client care and service delivery)?

The project was based on the assumption that learning should be career-long and that applying learning to practice – and identifying learning achieved within practice – is a cyclical process that is central to remaining competent. It built directly on an outcomes-based model for demonstrating competence through CPD developed by the Chartered Society of Physiotherapy. It also drew heavily on policies, tools and initiatives of each of the participating professions, including codes of conduct, standards of practice, CPD schemes and competence frameworks.

The project developed a common framework through a process of consensus-building. Profession-specific models were then developed. Each of these adhered to a set of shared principles and revolved around a series of outcomes, explanatory information, prompt questions and references to other relevant sources and tools. Cross-professional support materials were developed to help individuals reflect on their practice, articulate learning achievements and future needs, and supply related evidence.

A pilot exercise formed a key phase of the project. Within this, the draft models and support materials were tested with over 1300 AHPs across the UK in around 50 pilot sites, many of these multi-professional. Together, they captured the full profile of AHPs’ career stages, employment sectors and settings and occupational roles. Pilot participants were asked to use the draft outcomes model for their profession for two months and then to submit reflective statements, supported by appropriate forms of evidence, and complete an evaluation form. An overall response rate of 62.1% was received. However, within this, the responses from different professions was variable (ranging from 100% to 15%).

The main trends emerging from participants’ statements were

• A strong commitment to CPD, although significant issues were raised about AHPs’ access to the time and support necessary to engage with a demanding process
• Strong use of support structures, such as appraisal, peer review, clinical supervision, personal development planning, mentoring and portfolio-keeping, where these existed – but indications of their partial availability
• A wealth of promising material, but clear indications that AHPs need more support to participate in an approach to CPD that revolves around evaluating learning needs and achievements and how these impact on patient/client and service delivery (with this message coming across more strongly in some professions than others).

A number of exemplary features characterised participants’ statements. These included

• A strong patient-/client-focused approach to professional practice and service delivery
• A clear engagement in inter-professional practice
• A broad range of individual and team-based initiatives to enhance service delivery through changing practice and procedures.

The main trends in participants’ feedback were:

• A concern about the time available to commit to CPD
• The need for more support for CPD activity (particularly an approach that calls for a high level of critical thinking and reflection)
• The need for initiatives relating to CPD, competence and enhancing quality to be explicitly linked and integrated (something the project has sought to contribute to achieving)
• A sense that the draft models provide a useful tool for CPD – especially for structuring and reflecting on learning – but that their presentation needs to be simplified and, for some professions, for the materials to be developed and customised further to optimise their relevance and usefulness (e.g. to ensure that their intended focus on the core skills of everyday practice is clear)
• Ambivalence about how far the materials can enable individuals to provide evidence of their continuing professional competence without their containing a sharper focus on the technical elements of practice and being bolstered by additional requirements and mechanisms
• A related need for the approach to be underpinned by verification and monitoring systems (something that had deliberately been left out of the scope of the project).

The project’s recommendations have been informed by this feedback and that obtained through a consensus-building conference. They recommend that an outcomes-based approach to CPD is pursued, with further work done to simplify the materials and extend their profession-specific customisation. They also highlight the value of further AHP-wide work, subject to new funding being secured. The suggested focus of activity would be to:

• Develop robust, but flexible, verification and monitoring systems
• Enhance support for AHPs to engage in genuine reflection and a forward-thinking approach to their CPD
• Improve the presentation of the outcomes models and support materials (including the scope for their development in a web-based format)
• Ensure the models’ full integration with existing and developing schemes, tools and frameworks across the UK
• Explore more fully how demonstrable links between CPD and competence can be made, such that all can have confidence in any arrangements for the approach’s formal implementation.

The project has confirmed the strong value of the AHPs working together to undertake activity in areas of shared interest in a genuine spirit of collaboration. The materials produced as a result of the project have benefited significantly from the professions sharing their thinking and ideas. They have also been enhanced by input from other organisations, including user representative groups.
Introduction

1. This report presents the recommendations and conclusions of the allied health professions’ project on demonstrating competence through continuing professional development [CPD], as well as explaining how these were reached. The project has formed a genuinely innovative initiative, both in terms of the number of professions involved and its approach to CPD and professional competence. It had as its starting-point a wish to explore issues of common concern through collaborative working. This has involved developing a shared approach within which profession-specific differences can be recognised and respected, with the aim that this can be taken forward to benefit the professions both collectively and individually, while also addressing the needs of patients/clients, services and other significant stakeholders.

2. The project involved all the professions that currently come under the new Health Professions Council [HPC] and ran for eighteen months between January 2002 and June 2003. The report takes a cross-professional approach, in line with the broad consensus that the project has achieved. At the same time, it highlights where particular profession-specific issues have arisen and which require further consideration and work.

Participating professions

3. The fourteen professional bodies involved were as follows:

- Association of Clinical Scientists
- Association of Professional Music Therapists
- British Association of Art Therapists
- British Association of Dramatherapists
- British Association of Prosthetists & Orthotists
- British Dietetic Association
- British Orthoptic Society
- British Paramedic Association
- Chartered Society of Physiotherapy
- College of Occupational Therapists
- Institute of Biomedical Science
- Royal College of Speech & Language Therapists
- Society of Chiropractors & Podiatrists
- Society of Radiographers

4. The project was funded by the Department of Health for England. However, it was UK-wide in its coverage and perspective. This reflects the UK-wide membership of the participating professional bodies and issues around professional regulation and development being the same across England, Wales, Scotland and Northern Ireland (although their policy and organisational contexts may differ).

Structure of the document

5. The report is organised into the following sections:

- Section 1: The project’s rationale, purpose and context

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1 As indicated, all the professions currently regulated by the Health Professions Council participated in the project. For ease of reference, the professions are collectively called the ‘allied health professions’ or ‘AHPs’ throughout the document. However, it should be noted that this term and acronym are commonly used to refer to a narrower range of professions than were involved in this project.

2 The Association of Clinical Scientists entered the project in March 2003. Work has been conducted to a different timescale from that undertaken by the other participating professions. However, it is following the same process, as explained in Section 3.
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- Section 2: Underpinning concepts
- Section 3: Project stages
- Section 4: Refining the framework, models and support materials
- Section 5: Evaluating the project’s outcomes and process
- Section 6: The project’s recommendations
- Section 7: Summary and conclusions

The common framework and the generic outcomes model (from which profession-specific models were developed for the pilot and that continue to refined in light of this exercise) are attached as Annexes A and B. Appendices are also attached to provide background information (please see the contents page for a full list of these).

6. The evaluation report of the pilot phase of the project forms an important companion volume to the final report. Readers wanting more in-depth information on this part of the project are therefore encouraged to consult this (AHP project, 2003a).

A note on definitions

7. The project’s approach hinged on quite specific thinking on the nature of continuing professional development, competence and reflective practice and the value of an outcomes-based approach to learning. While these concepts are explored in more depth in Section 2 and Annex A (and are returned to in Sections 4, 5 and 6), it is important to bear in mind that the definitions given in Box A below form the project’s starting-point.

Box A: Core project definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Continuing professional development (CPD)</td>
<td>A wide range of learning activities through which professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice.</td>
</tr>
<tr>
<td>Competence</td>
<td>The complex synthesis of knowledge, skills, values, behaviours and attributes that enable individual professionals to work safely, effectively and legally within their particular scope of practice that has at its core concepts of professionalism, autonomy, self-regulation, awareness of the limits of personal practice and the practice of the profession to which individuals belong, and within which structured, career-long learning and development to meet identified learning needs forms an integral part.</td>
</tr>
<tr>
<td>Reflective practice</td>
<td>The structured process of reviewing an episode of practice to describe, analyse, evaluate and inform professional learning in such a way that new learning is identified, modifies previous perceptions, assumptions and understanding, and informs subsequent practice.</td>
</tr>
<tr>
<td>Outcomes-based approach</td>
<td>An approach to providing evidence of CPD that seeks to attest to on-going competence that focuses on individuals’ learning achievements, their application of learning to practice and the benefits of this, rather than simply input (e.g. the amount of time devoted to learning activities or the amount of credit accrued through undertaking formal learning programmes).</td>
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A full glossary of terms used in the project is attached as Appendix 1.

Navigating the document: Core themes and elements

8. The document, given the size and complexity of the project, is lengthy. It follows an essentially sequential, chronological structure to explain the work undertaken and the emerging recommendations and conclusions. Within this, several themes and elements are addressed throughout the document. Information on tracking these is given in Table 0 below.
Table 0: Key themes and elements in the document

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Section 1: The project’s origins, purpose and practical arrangements

Introduction

9. This section explains why the project came into being, its formal aims, objectives and intended outcomes, and the practical arrangements put in place to ensure the smooth-running of work within a tight timeframe.

Rationale: Drivers and policy context

10. The expected future introduction of re-registration requirements by the HPC provided a strong impetus within the AHPs to evaluate how tangible links could be made between CPD activity and competence and to develop tools that could enable individuals to demonstrate these links in credible and constructive ways (DoH, 2000a; DoH, 2001a). More broadly, the modernisation agenda within the NHS had increased the professions’ keenness to maintain, enhance and provide evidence of the quality of their contribution to patient and client care (DoH, 2000b; DoH, 2000c; DoH, 2001b; DoH, 2001c; DHSSPS, 2001; Scottish Executive, 2000; National Assembly for Wales, 2001).

11. In coming together to work on the project, the AHPs wished to demonstrate their commitment to developing an approach to CPD that could do the following:

- Maintain and raise standards of service delivery and achieve demonstrable links between individuals’ learning and improving patient/client care (whether directly or indirectly), as well as relate to their professional and personal developmental needs
- Encourage a commitment to evidence-based practice within the professions
- Promote the value of all types of learning activity (but particularly those that revolve around day-to-day practice and reflection)
- Ensure that the approach taken in AHPs’ learning and development relates closely to recent government initiatives around modernising the NHS and assuring quality through clinical governance, while having equal value and relevance to members of the professions practising in other public sector structures and organisations and to those working in the independent, private and voluntary sectors.

12. The professions intended that developing and testing an outcomes-based approach to demonstrating competence through CPD would both strengthen and demonstrate their capacity for self-regulation while providing practical tools for their members to plan, structure and evaluate their learning activity.

13. The expectation that future re-registration requirements would be framed in terms of CPD that could attest to individuals’ on-going competence meant that the relationship between learning activity and safe and effective practice could not simply be treated as an academic conundrum (DoH, 2001d). It therefore seemed incumbent on the AHPs to establish their thinking on the issue and to develop robust and tested approaches to how the link could be made and demonstrated to help individual professionals prepare for future requirements. There was also a keenness to guard against the potential of unhelpful, bureaucratic requirements being introduced that do little to maintain or enhance standards of practice in the interests of patient/client care by developing an approach that can genuinely protect the public and promote individual professionals’ on-going development.

14. Subsequent documentation has affirmed that re-registration requirements will be introduced by the HPC, with the intended introduction point being 2006, although the intention to link competence with CPD has become less clear (HPC, 2002a; HPC, 2002b; HPC, 2003). However, indications have been given that the HPC is committed to taking an outcomes-based approach to CPD and that it will consider the work of professional bodies in relevant areas, including that of the current project (AHP Project, 2002; HPC, 2002b; HPC, 2003).
15. Although impending re-registration requirements created a very tangible driver to the project, a broader value was envisaged in health care professions developing their thinking and activity around CPD and competence. Not least, an outcomes-based approach to learning ultimately focused on enhancing patient/client care was seen to fit strongly with government quality agendas, particularly that manifested in the concept of clinical governance (DoH, 1998).

16. Just as importantly, it was felt that a genuine linking of CPD and competence through a process of reflective practice should have benefits for individuals’ personal and professional development, the development of teams and the collective development of the professions’ identity and knowledge base (Errington & Robertson, 1998; Clouder, 2000; Swee Hong & Payne, 1998). It also followed that an outcomes-based approach to learning should lead to a better use of available time and resources; for example, by optimising opportunities for work-based learning in ways that accord with current government initiatives to develop the NHS (DoH, 2000a).

17. More broadly, then, the project fits with current policy initiatives around CPD. In particular, there is a discernible trend towards focusing on the outcomes of learning activity (and investing funds in schemes and approaches that stimulate a structured, planned approach to lifelong learning, underpinned by reflection and informed by identified learning needs), rather than more simplistic approaches to measuring learning in terms of time devoted to activity. It also fits with initiatives to take a more cross-professional approach to learning and development.

The project’s aims, objectives and intended outcomes

Aims

18. The aims of the project, as defined within the project plan were that, through inter-professional collaboration, to develop a common framework and profession-specific, but complementary, models that could

i. Verify and recognise the outcomes of individuals’ professional development in ways that can attest to their competence

ii. Achieve tangible links between CPD and enhancing service delivery and patient/client care by promoting a planned, structured and evaluative approach to learning and development and by emphasising the importance of the professions’ commitment to clinical effectiveness

iii. Provide an approach that could be used by the Health Professions Council for developing and enacting re-registration requirements, as well as having relevance and application to other purposes and activities (for example, local appraisal schemes and personal development planning)

iv. Produce an approach that is logistically and economically viable, that demonstrates the professions’ commitment to effective collaboration with one another, and that has the support of members of the participating professions and other relevant stakeholders

v. Produce an approach that has relevance to, and the potential for application by, other professions (including medicine and nursing) and support workers in health care, thereby optimising expenditure of resources and minimising duplication of effort (CSP, 2001a).

Objectives

19. The objectives of the project were to

i. Develop and evaluate a UK-wide outcomes-based approach to demonstrating competence through CPD that provides a useful structure for planning, undertaking, evaluating and recognising learning activity and that has the capacity to provide evidence potentially required for future re-registration requirements

ii. Formulate a common framework, or set of principles, within which each profession is able to develop a model for its members to demonstrate competence through CPD
iii. Map the range of materials developed by all participating professions that can assist in developing a common framework and profession-specific models
iv. Identify and evaluate the range of ways in which individuals can evidence their continuing competence, taking a lateral approach to potential sources of corroboration while placing reflective practice at the centre
v. Evaluate the appropriateness of locally-implemented arrangements for assuring the fulfilment of outcomes within a nationally-set framework (paying particular attention to the potential role of appraisal schemes, self- and peer review and personal development planning, and to the needs of members of the participating professions who are either self-employed or employees of organisations that do not operate staff appraisal and/or peer review systems)
vi. Assess through broader collaboration, the relevance and potential implementation of the framework for professions other than those participating formally in the project (AHP Project, 2001).

**Intended outcomes**

20. The intended outcomes of the project were to

i. Develop a common framework and profession-specific models to demonstrate competence through CPD
ii. Produce a range of tools, developed in light of identified need, to optimise help to individuals in demonstrating competence through CPD and, in particular, assist with reflective practice, articulating learning achievements and future needs, and providing appropriate evidence to corroborate reflective statements
iii. Present an approach to demonstrating competence through CPD that has the support of the participating professions, has credibility with other stakeholders and that could provide a template for creating re-registration requirements by the HPC
iv. Present an approach to CPD and competence that is of prospective relevance and interest to other health care professions and of potential application in the possible future regulation of health care support workers (AHP Project, 2001).

21. It was recognised at the planning stage that the project represented a complex and genuinely innovative programme of work. The project plan therefore highlighted that it was difficult to judge precisely how far the identified products could be finalised within the eighteen-month timeframe and that, while the professions were committed to fulfilling the aims, objectives and outcomes as given above, additional time might be required to refine the profession-specific models beyond the scope of the project. An evaluation of how well the intended outcomes of the project have been fulfilled is presented in Section 5.

22. The progress of work was monitored through

- The regular submission of draft documents and progress reports to the steering group (see below) and, via this, to the committees of the participating professional organisations
- The on-going appraisal of work against the project objectives, intended outcomes and timescale by the steering group and project team
- Regular reports to the Department of Health, as the project’s funder, within and outside the steering group meetings
- Seeking and analysing feedback from stakeholders, including through a consensus-building conference held in May 2003
- Conducting and evaluating the pilot exercise.

**Practical arrangements**

23. A steering group was formed to oversee fulfilment of the project plan. The group comprised representatives of each of the professions participating in the project (see the Introduction), together with other relevant stakeholders, including representatives of the Department of Health
and health government departments of the other UK countries, commissioning authorities, regulatory bodies and user representation groups.

24. The group's terms of reference are attached as Appendix II.

25. The Chartered Society of Physiotherapy (CSP) acted as the project manager, working in close collaboration with the other participating professions. A full-time fieldwork officer and a part-time project administrator were appointed by the CSP as dedicated project staff. The project team comprised these two officers, along with the CSP’s head of quality & standards and a professional adviser with a particular remit for issues around professional competence and the broad context of CPD issues (including strong links with the CSP’s clinical effectiveness unit). The holder of this post changed during the course of the project.

26. To facilitate collaboration, a project operations group was set up, comprising representatives of each of the participating professions. The group’s terms of reference are attached as Appendix III.

27. The project demanded a strong commitment from each of the participating professions. This primarily involved

- Representatives acting in an advisory capacity to the project team, primarily through the steering and operations groups but also on a regular basis outside meetings via email and telephone contact
- Representatives assisting the fieldwork officer in running induction and concluding workshops as part of the pilot exercise
- Member involvement in the consultation arrangements and pilot exercise (including through representatives acting as scrutineers to consider statements submitted by pilot participants)
- Professional bodies’ bulletins and magazines carrying regular updates on the project, as well as initial advertisements for the dedicated project posts and canvassing for prospective pilot sites
- Representatives assisting in running the consensus-building conference, including through chairing the day, presenting, and acting as facilitators for workshop sessions
- Hosting meetings of the steering and operations groups.
Section 2: Conceptual underpinnings

Introduction

28. A crucial dimension of the project was agreeing and refining a firm conceptual foundation for the production of the outcomes models and related support materials. This was important for two reasons:

- The project was genuinely innovative in seeking to make more tangible the links between demonstrating on-going competence and CPD by taking a structured, yet flexible, and forward-thinking approach to both concepts (CSP, 2001b; Gosling, 1999; Gosling, 2002)
- The project was unprecedented in constituting a free-standing, genuinely collaborative activity between the fourteen AHPs to address a substantial, but focused, issue.

29. Work was done in the project's early stages to establish an appropriate approach for undertaking developmental activity. There was also a need to ensure such an approach was founded on a common outlook, within which different professional nuances and characteristics could be respected and recognised. This section rehearses the main areas in which consensus was reached, initially through a seminar convened in March 2002 and through subsequent discussion throughout the project.

30. The principles agreed were expressed within a common framework and carried through the profession-specific outcomes models (see Annexes A and B). In undertaking developmental activity, strong account was taken both of the baseline report produced in the early months of the project (Appendix IV), and specific research-based and developmental work that had been taken within some of the participating professions (CSP, 2000; Gosling, 1999; Williamson, 2001).

Professionalism and competence

31. It was agreed that key expectations of what it is to be a professional needed to be embedded in thinking on competence. This seemed a promising way of doing justice to the complexities of practice and the responsibilities that professional status implies and carries. Achievement of this integration was seen as crucial to demonstrating the AHPs' fitness to carry the privileges of autonomy and self-regulation that being a member of a profession confers, while reflecting the underlying values and thinking of the professions themselves. The key concepts encapsulated in the balance between professional responsibility and privilege are illustrated in Figure 1 below.

Figure 1: Elements of professionalism

Patient/client-focused practice, underpinned by sound clinical reasoning and professional judgement, on-going reflection, and critical application of the evidence base

Professional responsibility, manifested in adhering to code of conduct/standards of practice, undertaking structured, evaluated CPD to meet identified learning needs, and engaging with the full implications of clinical effectiveness

Professional privilege, expressed through professional autonomy and self-regulation

32. The following fundamental principles of professionalism were therefore agreed to be central:

- A motivation to deliver a service to others
• Adherence to a moral and ethical code of practice
• Striving for excellence, maintaining an awareness of limitations and scope of practice
• The empowerment of individuals and teams (Hodkinson, 1995; Medical Professionalism Project, 2002).

33. Further to the above, it was agreed that the project should promote the following basic elements of professional competence:

• Individuals have a responsibility to ensure the safety and efficacy of their practice
• Individuals need to be able to think critically about what they do, rather than simply dealing with the routine or technical elements of their role
• Individuals’ competence does not exist in a vacuum, but is determined in part by their interaction with others and their ability to act, influence and respond appropriately in whatever contexts they practise (Ellis, 1988; Hodkinson, 1995; Pearson, 1984).

34. There was a need to guard against negating or undermining the fundamental and core attributes of professional practice. A number of writers have highlighted the limitations and potential dangers of simplistic, reductionist competence models such as those that can be summed up by the terms ‘behaviourist’ or ‘technical-rational’ approaches (Ashworth & Saxton, 1990; Ashworth, 1992; CSP, 1999; Gonczi, 1994; Hodkinson & Isitt, 1995; Hyland, 1995). In addition, it was recognised that too much can be expected of any approach; none can serve as a panacea or perfect model, or realise the ambitious agenda that has sometimes been set for competence-related work (Norris, 1991).

35. It was therefore agreed it was important to pursue an approach to competence that

• Focuses on the broad attributes of professional practice, avoiding inappropriate prescription or constraint and recognising the complexity of professional activity
• Is inclusive of individuals at all career stages and in all practice settings, employment sectors and occupational roles
• Promotes individual responsibility for ensuring the safety and effectiveness of their practice while acknowledging the broad range of factors that can impact on their competence at particular times or in particular roles or settings and employers’ role and responsibilities
• Recognises the ethical and emotional dimensions of professional practice
• Emphasises individuals’ ability to think critically about what they do, rather than simply dealing with the routine or acting at technician level
• Promotes the dynamic relationship between learning and practice and the principles of adult learning
• Revolves around the principles of trust and self-evaluation, while ensuring safety and effectiveness are at its core
• Recognises the dynamic relationship between individuals’ scope of practice – and therefore competence – and that of the profession
• Recognises that individuals’ competence relies on their effective interaction with others and their ability to act, influence and respond appropriately within the contexts in which they practise
• Recognises the evolving nature of professions’, and individual professionals’, competence.

36. In turn, it was agreed that these principles should be translated into an understanding that individual competence

• Must be shaped by adherence to the code of conduct for the profession to which an individual belongs
• Is not static
• Relates to their practice forming part of the broader terrain of their profession’s scope of practice
• Is more than about clinical skills - whether or not an individual's role is primarily that of a clinician.

37. Conversely, it was agreed that a meaningful approach to professional competence needs to acknowledge that safe and effective practice is more than

• Just the concern, or within the preserve, of the individual – contextual factors, including social and institutional structures and cultures, teamworking and interpersonal interaction, also play a part (Hodkinson, 1995)
• About the implementation of knowledge, understanding and skills – it is dynamic, ever-changing and informed by individuals’ life history, habitus, context of practice and interaction with others (Hodkinson, 1995; Schwammle, 1996)
• About establishing and maintaining safety to practise, although this has to be at its core
• About an individual’s ability to perform a particular job role, although this has to be central in defining current scope of practice;
• A focus on an individual’s past practice, but needs to encourage a forward-looking, dynamic approach that promotes implementation of the learning cycle (Kolb & Fry, 1975; DoH, 2001c).

Scope of practice

38. Formulating an appropriate approach to professional competence forces questions about the scope of individuals’ practice and how this develops over time. Issues also arise as to how, and by whom, individuals’ scope of practice should be defined, and how much flexibility should be permitted within such a definition. At one extreme, individuals could be given complete freedom to define their own scope of practice and, therefore, to select those areas on which they submit evidence that attests to their competence. At the other, the scope of practice might be pre-set and universal for practitioners, regardless of their career stage, level of seniority, experience and specialisation, the patient/client group with whom they practise, and the practice or occupational setting in which they work.

39. It was agreed that neither extreme seemed desirable nor sustainable. Giving individuals complete discretion to define the scope of their practice raised issues of credibility and robustness, since they could potentially skew their focus to those areas in which their competence was strongest and ignore those areas in which their competence might be questionable. But imposing a universal scope of practice on all members would negate the diversity and degree of professional specialism, individual responsibility for defining their own scope of practice, and the evolving nature of individuals’ – and professions’ – scope of practice. It would also undermine the sense in which competence can only truly be defined if it is seen in the context of individuals’ professional role and setting at any point in their career.

40. There was therefore a keenness to develop a constructive and meaningful concept of scope of practice that

• Acknowledges the diversity of practice within a profession, while promoting the notion of professional cohesiveness and identity through core, common outcomes that have application across the whole
• Places a profession’s rules of conduct at the centre of the process, thereby emphasising individuals’ professional responsibility for limiting their practice to those areas in which they have established and maintained their competence
• Emphasises the importance of individuals evaluating and reflecting on their practice by making their capacity to articulate their fulfilment of specified outcomes fundamental to the measurement of competence
• Recognises the developmental and shifting nature of individuals’ competence as they progress through their career.
Making tangible links between competence and CPD

41. While a simple faith in CPD ensuring individuals’ competence is misplaced, it was felt that an approach to on-going learning and development predicated on reflection, planning and evaluation could go a long way to ensuring the link. In short, premising CPD on a thorough evaluation of learning needs, achievements and the impact of applied learning on practice, should mean that activity – together with its evaluation – should attest to individuals’ competence (see core project definitions given on page 10).

42. It seemed paramount that individuals should be helped to plan their CPD in accordance with their identified learning needs and plan how they wished, and needed, to develop their practice in the future. In turn, they needed a structure that enabled them to review whether their learning needs had been met through their learning activity and to articulate and demonstrate their learning achievements in relation to their current and future practice.

43. Such a process was seen to demand an on-going, cyclical and forward-thinking approach to learning, in which individuals constantly review their development needs. Crucially, this allows no room for complacency and undermines any assumption that CPD might become irrelevant or unnecessary as individuals reach certain career stages. In addition, it builds into the concept of professional competence a dynamic dimension within which demonstration of a commitment to planned, structured and evaluated CPD becomes a fundamental component. A simple retrospective focus on individuals’ activity was deemed insufficient.

44. It was agreed that an approach to CPD that encourages and supports individuals in planning, structuring and reflecting on their learning should help them to achieve and demonstrate the links between their on-going learning and development and their competence. At the same time, it was recognised that there is often a gap between what is seen as the most appropriate approach to CPD and the predominant culture and mindset; that is, an undue emphasis and value attached to course attendance and too little time and recognition given to work-based learning and related reflective activities (CSP, 1999a; CSP, 1999b; O’Sullivan, 2003). For help to have maximum effect, therefore, it was recognised that it needs to encourage a broad-ranging approach to learning and to put to the fore the importance of CPD activity being grounded in reflection, evaluation and everyday practice.

Appropriate forms of evidence

45. Some consideration was given to how individuals might eventually demonstrate their fulfilment of outcomes of competence, given that this would impact directly on what was practicable in terms of how the outcomes were formulated and expressed (for example, very tightly defined outcomes would carry different implications for acceptable types of evidence than more non-prescriptive approaches). As a starting-point, it seemed sensible that expectations of evidence should

- Be based on a portfolio-style approach to ensure an appropriate level of flexibility and to promote reflection and evaluation
- Safeguard the confidentiality of individuals, their patients/clients and their colleagues
- Create a minimum workload for individuals and guard against appearing threatening or daunting
- Aid individuals in their personal and professional development
- Be capable of attracting external trust and credibility.

46. Similarly, it was noted that there were essentially three broad types of evidence that could be used to support individuals’ engagement in a structured approach to demonstrating competence through CPD:

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3 More information on the approach to evidence within the project is provided in Appendix III to the Pilot Evaluation Report (AHP Project, 2003a).
• Analogous – ones rooted strongly in everyday professional practice
• Analytical – ones requiring individuals to stand back from, and evaluate, their practice
• Reputational – ones drawing on verification from individuals’ colleagues (Woodruffe, 1992).

47. It was agreed that it would be helpful to draw upon a mix of these, while a process of considering submissions should adhere to the key criteria of validity, reliability and objectivity (Fabb & Marshall, 1983).

48. In essence, it was agreed that the approach adopted should promote self-reflection and self-evaluation, be predicated on outcomes, and encourage a forward-looking perspective (Boam & Sparrow, 1992; Donen, 1999; Elliott, 1991; Humphrey & Geissinger, 1992; Latimer & Noble, 1991). At the same time, recognition was given to the criticisms of such approaches – that they can lack transparency, accountability, credibility and place too much trust in the individual (Bradshaw, 1998).

49. The principles identified within work to develop basic concepts were used directly to inform the production of a common framework and the subsequent development of the draft profession-specific outcomes models (see Annexes A and B).
Section 3: Stages of the project

3a: Project schedule and methodology

Project schedule

50. The project comprised five main phases of activity, as outlined in the Table 3i below.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Activity</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mapping exercise and production of baseline report</td>
<td>Jan./Feb.2002</td>
</tr>
<tr>
<td>2</td>
<td>Development of draft common framework and profession-specific</td>
<td>Mar.-Aug.2002</td>
</tr>
<tr>
<td></td>
<td>models</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Piloting the draft models across the UK</td>
<td>Sept.2002-Feb.2003</td>
</tr>
<tr>
<td>4</td>
<td>Evaluation of pilot exercise and refinement of draft models,</td>
<td>Mar.-May 2003</td>
</tr>
<tr>
<td></td>
<td>including through convening a consensus-building conference</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Preparation and submission of final report and recommendations</td>
<td>June 2003</td>
</tr>
</tbody>
</table>

51. The project steering group met at key stages within the above phases of activity to approve work that had already been undertaken and to sanction the appropriate direction of prospective work. The schedule and focus of its meetings is summarised in Table 3ii below.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Timing of meeting</th>
<th>Main focus of meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>February 2002</td>
<td>Establish and agree remit through a workshop-based approach; appoint chair and vice-chair</td>
</tr>
<tr>
<td>2</td>
<td>April 2002</td>
<td>Approve baseline report; discussion and approve draft common framework and approach for developing draft profession-specific outcomes models</td>
</tr>
<tr>
<td>2/3</td>
<td>September 2002</td>
<td>Discuss and approve draft profession-specific outcomes models; discuss and approve arrangements for the pilot exercise</td>
</tr>
<tr>
<td>4</td>
<td>March 2003</td>
<td>Discuss initial findings from the pilot exercise</td>
</tr>
<tr>
<td>4</td>
<td>May 2003</td>
<td>Discuss draft evaluation report and plans for consensus-building conference</td>
</tr>
<tr>
<td>5</td>
<td>June 2003</td>
<td>Discuss and approve evaluation and final reports</td>
</tr>
</tbody>
</table>

52. The project operations group met at points that best fitted within the above timeframe. Generally, it met around two weeks before each steering group meeting, enabling ideas and thinking to be fed into the steering group (facilitated by some cross membership across the two groups). On one occasion (March 2003), the groups met within one meeting to facilitate joint consideration of issues emerging from the pilot exercise (AHP Project, 2003a).

Project methodology

53. The project methodology was developed primarily to expedite the progress of complex developmental work, involving a large number of partners, and to ensure the project outcomes would be worthy of support from all relevant stakeholders, including the participating professions. It revolved around enabling professions to pool their knowledge, expertise and experience and to facilitate testing and seeking feedback on draft materials. The viewpoints of other stakeholders were gained through their membership of the steering group and their being involved at key consultation points.

54. The early stages of the project formed the essential underpinnings to the major elements of project activity and provided a secure basis for subsequent cross-professional collaboration.

55. Project tasks were undertaken through the following:

- Workshops and seminars
• Meetings with participating profession representatives and other appropriate stakeholders (including user involvement representatives)
• Organising, supporting and conducting a pilot exercise
• Analysis and evaluation of the pilot
• A consensus-building conference to synthesise the results of the pilot
• Desk-based activity to develop and refine the common framework, the profession-specific models and related support materials.

3b: Initial developmental work

Mapping exercise and production of baseline report

56. The first two months of the project (January/February 2002) were devoted to undertaking an initial mapping exercise of all relevant materials produced by the participating professional bodies. The purpose was to ensure documentation - including policies, tools and schemes relating to competence and CPD produced by each of the professions - was considered and that it underpinned all subsequent project work, both in developing a common approach and in drafting profession-specific outcomes models.

57. Professional bodies were encouraged to think broadly about what might be relevant to the project. They were provided with a checklist (not intended to be exhaustive) of the kinds of materials that could usefully be fed into the process (attached as Appendix V. Key documents identified included

• Codes of professional conduct
• Standards of practice
• CPD policies, tools and schemes
• Statements, frameworks for, and approaches to, professional competence
• Materials relating to clinical effectiveness.

58. The receipt of information from professional bodies was supplemented by the fieldwork officer meeting with a representative of each of profession, along with representatives of the Department of Health, the HPC, workforce development confederations in England (WDCs) and a user representative group. These followed a semi-structured interview format, enabling common themes to be pursued with each, with appropriate adaptation depending on the nature of the organisation consulted. The broad question areas raised in the interviews are attached as Appendix VI.

59. The policies, ideas and views emerging through submitted materials and the interviews confirmed that the participating professions had a large amount of common ground on which to build. In particular, their codes of conduct - and, where they existed, standards of practice - indicated a high degree of resonance in terms of the principles underpinning professional practice and capacity for self-regulation.

60. A universal feature of the professional bodies’ codes of practice was an expectation that their members engage in appropriate forms of CPD to maintain their on-going competence to practise. The precise framing of expectations around CPD varied, with some bodies, for example, requiring their members to undertake a certain amount, or certain types, of CPD within a specified time period.

61. The series of interviews indicated that the participating professional bodies and others shared a common aspiration that commitment to CPD should be strengthened by an approach that focuses on the outcomes of activity; that is, what individuals achieve through their learning and how they apply their learning to their practice.
62. Feedback gained through the interviews also indicated a broad support for pursuing an outcomes-based approach to CPD founded on

- A focus on patient/client care and enhancing service delivery
- Cross-professional activity
- Respect for, and recognition of, professional difference.

63. The baseline report, produced by the fieldwork officer as a result of the initial exercise, is attached as Appendix IV.

**Developing the common framework**

64. Having established common ground through the initial mapping exercise, the next step was to formulate principles to which all participating professions, and other significant stakeholders, could agree and which could be expressed through producing a common framework. The purpose of the framework was to inform the development of the profession-specific outcomes models.

65. A one-day seminar was convened in March 2002 to develop the framework's principles. This used informal consensus-building techniques to establish where shared thinking lay and to identify issues on which resolution was required. A background paper was provided to participants that rehearsed key issues around professional competence, professionalism, scope of practice and CPD (Gosling, 2002; see Section 2).

66. The day formed a very positive exercise. From discussion, ideas were distilled to produce a common framework. This was approved by the steering group in April 2002 as a working document for the next stage of the project. It is attached in its finalised format as Annex A.

**Developing the draft profession-specific models**

67. Development of the draft profession-specific models began in the spring of 2002. Along with the common framework, the principal starting-point for the models' development was a generic outcomes model. This was derived from the original model developed for members of the Chartered Society of Physiotherapy (CSP, 2001). The following documents were also produced to facilitate work with each of the professions and to ensure a consistent approach to activity:

- A series of questions designed to help professional body representatives consider how the generic model needed to be developed, customised and nuanced to make it suitable for their members
- Background information on the origins and aims of the outcomes-based approach to demonstrating competence through CPD.

Information on the process for developing the draft profession-specific models is provided in Appendix VII.

68. It was agreed by the steering group that professions should not be required to adopt the generic model without substantial change. However, it was expected that they would adhere to the template’s basic structure; that is, by including

- A series of outcomes designed to encapsulate competence for the profession in question
- Prompt questions to stimulate thinking and reflection on learning and practice
- References to relevant support material (principally codes, tools and policies produced by the professional bodies themselves).

69. The project fieldwork officer worked with representatives of each profession to produce draft profession-specific models. The precise arrangements for this activity varied, depending on the wishes and style of working of each profession.
• For some, activity was taken directly through existing committee structures
• For others, a small group of members and officers was formed expressly for the purpose
• For others, the work was done primarily in liaison with officers, with reference through email and other contact to member representatives.

70. In practice, none of the professions chose to deviate significantly from the generic model supplied for developmental purposes. This is not to say that each did not give careful consideration to how the model needed to be developed to meet the needs of their members; rather, that they felt comfortable with using the six outcomes offered within the original for testing within the pilot exercise.

71. One profession (art therapy) chose to add a seventh outcome relating to cultural competence (see below). Another (occupational therapy) made minor changes to the wording of some of the original outcomes. In retrospect, that the professions tested out draft models that were strongly similar within the pilot exercise enhanced this activity, since it meant that broad comparisons and generalisations could be made across the professions (see AHP project, 2003a).

72. Draft profession-specific models were submitted to the steering group’s September 2002 meeting. This followed each professional body ensuring it was happy for its draft to be used within the pilot exercise. Approval was given by the steering group for the drafts to be used as the focus of the exercise, on the understanding that the materials would be reviewed, developed and refined, as appropriate, in response to participant feedback (see Section 4; AHP Project, 2003a). The generic outcomes model is attached as Annex B. A prefatory note is attached to the annex to explain planned activity that will occur beyond the life of the project.

3c: The pilot exercise

Arrangements for piloting the draft models

73. The pilot was undertaken to test out use of draft profession-specific outcomes models with representatives of each profession across the UK and to gain feedback on the draft materials from the pilot participants. The criteria used for the selection of sites are attached as Appendix VIII.

74. Participants were asked to work with their relevant profession-specific draft model for a period of two months within an approximate three-month period (November 2002 to mid-February 2003). They were then asked to submit anonymous reflective statements, supporting evidence and a completed evaluation form (see Appendix IX).

75. Key materials supplied to participants, in addition to the draft profession-specific outcomes models, were a Guide for Participants and a Fictitious Case Scenario Pack (AHP Project, 2003b; AHP Project, 2003c).

Response rate

76. A total of 1310 participants were involved in the pilot across thirteen professions and throughout the UK. 813 submissions were received at the end of the exercise, forming an overall response rate of 62.1%. Within this, 642 statements were received for evaluation (a response rate of 49%), while 663 evaluation forms were returned (a response rate of 50.6%). A full breakdown of submissions by each profession is provided in Tabled 3iii below.
Table 3iii: Summary of submissions from the pilot exercise

<table>
<thead>
<tr>
<th>Profession</th>
<th>Total No. of pilot participants</th>
<th>Total No. of submissions</th>
<th>% of submissions in relation to no. of participants</th>
<th>No. of Statements</th>
<th>% of statements in relation to no. of participants</th>
<th>No. of evaluation Forms</th>
<th>% of forms in relation to no. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Art Therapists</td>
<td>12</td>
<td>14</td>
<td>(116.7)</td>
<td>8</td>
<td>66.7</td>
<td>11</td>
<td>91.7</td>
</tr>
<tr>
<td>Biomedical Scientists</td>
<td>69</td>
<td>14</td>
<td>20.3</td>
<td>9</td>
<td>13</td>
<td>13</td>
<td>18.8</td>
</tr>
<tr>
<td>Chiropodists/Podiatrists</td>
<td>152</td>
<td>23</td>
<td>15.1</td>
<td>21</td>
<td>13.8</td>
<td>20</td>
<td>13.2</td>
</tr>
<tr>
<td>Dietitians</td>
<td>57</td>
<td>38</td>
<td>66.7</td>
<td>21</td>
<td>59.6</td>
<td>32</td>
<td>56.1</td>
</tr>
<tr>
<td>Dramatherapists</td>
<td>6</td>
<td>3</td>
<td>50.0</td>
<td>3</td>
<td>50.0</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Music Therapists</td>
<td>20</td>
<td>10</td>
<td>50.0</td>
<td>3</td>
<td>15.0</td>
<td>9</td>
<td>45.0</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>302</td>
<td>191</td>
<td>63.2</td>
<td>158</td>
<td>52.3</td>
<td>176</td>
<td>58.3</td>
</tr>
<tr>
<td>Orthoptists</td>
<td>44</td>
<td>35</td>
<td>79.5</td>
<td>31</td>
<td>70.5</td>
<td>28</td>
<td>63.6</td>
</tr>
<tr>
<td>Paramedics</td>
<td>50</td>
<td>11</td>
<td>22.0</td>
<td>8</td>
<td>16.0</td>
<td>11</td>
<td>22.0</td>
</tr>
<tr>
<td>Paramedics</td>
<td>50</td>
<td>11</td>
<td>22.0</td>
<td>8</td>
<td>16.0</td>
<td>11</td>
<td>22.0</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>321</td>
<td>279</td>
<td>86.9</td>
<td>214</td>
<td>66.6</td>
<td>206</td>
<td>64.2</td>
</tr>
<tr>
<td>Prosthetists/Orthotists</td>
<td>8</td>
<td>5</td>
<td>62.5</td>
<td>4</td>
<td>50.0</td>
<td>5</td>
<td>62.5</td>
</tr>
<tr>
<td>Radiographers</td>
<td>106</td>
<td>62</td>
<td>58.5</td>
<td>45</td>
<td>42.5</td>
<td>56</td>
<td>52.8</td>
</tr>
<tr>
<td>Speech &amp; Language Therapists</td>
<td>163</td>
<td>127</td>
<td>77.9</td>
<td>104</td>
<td>63.8</td>
<td>93</td>
<td>57.1</td>
</tr>
<tr>
<td>Unspecified profession</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>100</td>
</tr>
<tr>
<td>Totals</td>
<td>1310</td>
<td>813</td>
<td>62.1</td>
<td>642</td>
<td>49.0</td>
<td>663</td>
<td>50.6</td>
</tr>
</tbody>
</table>
Evaluating the pilot exercise

Arrangements were made to evaluate participants’ statements that involved representatives of each of the professions acting as scrutineers. Members of the project team looked at statements across the professions, as well as analysing data from the evaluation forms and other channels through which feedback was sought (AHP Project, 2003a).

Emergent trends

The key inferences drawn from the pilot exercise are outlined below.

- The draft models were generally felt to provide a useful structure for individuals to reflect on their recent professional development, with 62.5% of respondents answering the evaluation form question on this point positively. Within this, the proportion of positive answers from respondents from the different professions ranged from 100% to 34%. A smaller proportion of respondents overall indicated that they found the materials helpful in reflecting on what they had achieved and how they wanted to develop in the future (55% and 49% respectively). This was in keeping with participants’ reflective statements being less strong on these points (see below).
- It is more questionable how far the outcomes models, in their draft format and without their being bolstered by robust systems of verification and monitoring, could enable individuals to demonstrate their on-going professional competence in a reliable and fair way. This requires more detailed consideration, including a review of whether demonstrating on-going professionalism is a more appropriate focus of the models.
- The intended links between the draft outcomes models and existing national and local structures, schemes and initiatives that relate to CPD and enhancing the quality of professional practice and service delivery need to be made more explicit.
- In-depth consideration needs to be given to how AHPs can better be supported in taking a genuinely reflective, outcomes-based approach to their CPD.
- Strong consideration needs to be given to how the draft outcomes models and the related support and guidance materials can be made more user-friendly through their being simplified and reduced in size.
- Some participants produced exemplary statements in terms of the quality of reflection and evaluation they presented. However, it was clear overall that the exercise was demanding and that participants generally would have benefited from more advice and help than could be made available within the pilot on thinking through how their recent learning and practice related to the outcomes and therefore optimising what, in many cases, was promising material. This indicates strongly that AHPs need more support and guidance in thinking critically about their practice and learning and articulating the outcomes of this in terms of learning needs and achievements if they are to engage genuinely with an outcomes-based approach to their CPD.
- There was some variation across the participating professions in terms of how they responded to the draft materials, both in their feedback and how they completed the exercise of preparing statements (AHP Project, 2003a). This has highlighted the need to consider how the draft models can be customised further to ensure that they contain sufficient and appropriate profession-specific nuances, including more explicit reference to the core activities of day-to-day practice, particularly within some professions (see Annex B).

While the trends emerging from participants’ statements and their feedback were largely common across the professions, there were some significant variations in the levels of response rates in some professions (see Table 3iii). In addition, some profession-specific issues arose through the exercise, particularly for the professions that have a strong technical focus within their professional practice. Concerns on this front have been explored through follow-up meetings between the fieldwork officer and professional body representatives, as well as through final steering group meetings.

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4 A full evaluation of the pilot exercise is provided in a separate report (AHP Project, 2003; see especially Section 3).
meetings and sub-meetings. The prefatory table within Annex B highlights profession-specific action that has been identified to date.

80. The conclusions drawn from the pilot exercise were used to identify how the draft outcomes models and support materials needed to be developed and refined and to inform the development of plans for further collaborative work across the AHPs (see Sections 4 and 6 and Annex B).

Evaluating the process

81. Careful consideration has been given to how well the pilot worked as a process. The paragraphs below reflect on the positive features of the exercise, as well as areas where lessons have been learned and where broader contextual factors appear to have impacted on how the exercise ran and how it was perceived by those involved.

- Positive features

82. The pilot exercise was essentially successful in fulfilling its intended purpose, as outlined below.

- It involved representatives of all the professions engaged in the project at the time in a way that satisfied the pre-set criteria for sample selection (including a reasonable spread of representation from across the UK and spread of participants at different career stages, from different employment sectors and settings, and in a wide range of occupational roles; see Appendix VIII).
- It enjoyed a good overall response rate (62.1%), testament to the commitment and willingness of AHPs to engage with new work in the area of CPD and to devote time and effort to a complex exercise (although see below for issues around the degree of variation across professions in their response rates).
- It subjected the draft materials to a large-scale process of testing and critiquing, within which an inclusive approach and open approach was promoted, and from which a number of inferences could be made about how the materials need to be developed further.
- It involved a large number of members of the participating professions in evaluating participants’ statements, guided by a standardised process and subjected to a process of moderation. At the same time, it is acknowledged that the scrutiniser system was inevitably affected by differing perceptions and expectations brought to the task that could only partially be addressed through providing guidance and pro formas.
- Participants’ submissions (in the form of reflective statements and completed evaluation forms) provided a wealth of data for analysis, from which it has been possible to draw inferences about how the draft materials needed to be refined and developed (see Section 4 and Annex B).
- Participant feedback generally indicated a broad sense among the AHPs that the draft models offer a valuable additional tool to help them to engage in a planned, structured and evaluated approach to their CPD (although members of the professions do not greater support in engaging with such an approach, while responses to the materials were not wholly uniform across the professions5).
- There was some sense in which the outcomes contained within the draft models were seen to encapsulate competence for the professions concerned, although confidence in the process did vary across the professions, while it is clear from the feedback generally that this dimension of the approach and the project’s aims requires further exploration (see below and Section 4).
- Participants’ statements contained some promising material, with some submissions displaying exemplary features - either in terms of their quality as reflective statements or in revealing model features of professional practice – while others presented obvious areas for development (again, raising issues of support; see below). Where statements were

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5 See Section 3 of the evaluation report on the pilot (AHP, 2003).
particularly strong in terms of how they approached the exercise, they tended to show
explicit links between the elements highlighted in Figure 2 below.

- Generally, participants’ feedback endorsed the value of the project’s cross-
  professional approach within which profession-specific characteristics, nuances and
  expectations were incorporated (this has highlighted the potentially strong value of future
  work to develop cross-professional support materials; see Section 6).

Figure 2:
Linkages that were explicit within strong statements

![Diagram showing linkages between professional practice, CPD activity, service delivery, reflection, and competence.]

Issues requiring further consideration

83. It would be wrong either to be complacent about the pilot exercise’s success or to infer that further
work to develop and refine the draft materials is not needed. Feedback also highlighted the need to
review the project’s underpinning concepts. The lessons and messages outlined below were
particularly drawn from the exercise.

- **The pilot suffered from problems of time**, both in the sense of its particular scheduling
  within the calendar year and the relatively short period that could be afforded within the
  project’s overall timescale for pilot participants to engage with the materials. Any further
  work would need to be informed by consideration of how a greater sense of ‘real time’
  could be built into a piloting phase, with greater care taken to avoid periods in the year that
  are especially likely to inhibit individuals’ ability to use the materials fully (AHP Project,
  2003a).

- **The response rates within the pilot varied significantly across the participating
  professions** (see Table 3iii), making it difficult to conclude with confidence within some
  that the approach was tested with sufficient thoroughness or by a representative sample of
  the whole professional population. This would need to be addressed in any further work by
  seeking to bolster numbers, as well as explicitly seeking to redress perceived gaps in
  coverage; for example, private practitioners in the professions where these exist in
  significant numbers.

- **Delays in the evaluation exercise inevitably arose because of the high level of
  responses from participants and the sheer volume of paperwork this created.** While
  the reason for the delay was very positive, any future work would need to explore ways of
  streamlining approaches, creating more realistic timescales and ensuring resources were
  sufficient to cope with the presented workload.

- **The process of involving representatives of each profession in the evaluation
  process, with limited scope for standardising this through guidance and training, naturally risked a variety of perspectives and expectations being brought to the**
exercise. While the consequences of this appear to have been minimal, efforts to increase the robustness and standardisation of approach would need to be considered in any further work (AHP Project, 2003a).

- Feedback indicated that the draft materials require development and refinement to
  - Give sufficient priority to key messages and expectations
  - Streamline and simplify them (both in terms of format and language)
  - Increase their logicality of presentation and user-friendliness
  - Review the optimal format for their delivery (including scope for their production in a web-based format).

- Particular consideration needs to be given to conveying the intention that the models should complement existing local and national structures, schemes and tools to allay perceptions that they are new, separate and present a heavy additional workload for already busy professionals.

- Similarly, consideration needs to be given to conveying more effectively the intended encapsulation of all approaches to CPD (including work-based learning, attendance on formal courses and reflection on learning and practice) and all focuses of CPD activity, including the development of profession-specific knowledge and skills, as well as the extension and refinement of broader professional attributes and behaviours (see Section 2 and Annex A).

- More in-depth consideration needs to be given to how tools, training and other materials can be developed to enhance support. The scale of this means it would need to be taken forward through a separate piece of project work, although initial ideas and recommendations have been generated in the closing stages of present activity (see Annex B).

- Consideration needs to be given to conveying messages about the parameters and limits of the project’s scope so that misconceptions do not arise that it has failed by not developing or testing verification or monitoring mechanisms.

- The scope for making tangible links between CPD and AHPs’ on-going demonstration of professional competence requires in-depth review. This hinges on developing a more solid consensus on the key features of professional competence, making more explicit the models’ intended focus on what forms the core of individuals’ professional practice, and developing appropriate processes and mechanisms to support formal implementation (see below and Section 2).

- Work should be done to explore ways of developing robust, yet flexible, forms of verification and monitoring. This lay outside the scope of current project activity and would need to form a focus within any further commissioned project work.

Broader contextual issues

84. In addition, some issues that sat outside the project had a notable impact on the pilot. These will continue to have a profound effect on how members of the AHPs are able to engage with an outcomes-based approach to CPD, and need to be given strong consideration. Particular issues are outlined below.

- AHPs’ ability to engage with an approach that requires a systematic and critical approach to their on-going learning and practice needs to be sustained by appropriate forms of support. This includes time, resources and access to tools, training and mentoring to encourage and develop individuals’ confidence in reflecting on their learning and practice and their ability to articulate the on-going cycle of their professional learning and development.

- It needs to be recognised that there may be some variation across the AHPs in terms of how ready and receptive they are to adopt an outcomes-based approach to CPD. Such a readiness is likely to depend partly on current patterns and factors in their professional practice, different practice settings and varying levels of existing exposure to, and access to support for, engaging in reflective practice. What is clear is that the
presentation of the approach, and related support materials, needs to reflect current trends in different professions’ CPD activity, use language with which different professions are familiar, and be framed carefully to ensure it accords with different professions’ profile and priorities.

- It is inevitable that there will be high levels of anxiety over the next couple of years among AHPs until it becomes apparent how the HPC intends to move forward with implementing re-registration requirements (HPC, 2003). In turn, it seems inevitable that this will colour how initiatives to explore related areas are perceived. This can be seen as having a positive and negative impact: positive in the sense that the focus on future re-registration requirements is stimulating strong interest in CPD; negative in the sense that the spectre of new regulatory requirements has the scope to skew and inhibit how individuals think about, and engage with, CPD.
3d: Gaining wider perspectives

User involvement
85. Securing user group perspectives was seen as central to ensuring the validity of the draft models. Views were sought through three avenues:

- Inclusion of a representative from the Patients’ Forum on the project steering group
- Personal one-to-one interviews
- Telephone and email consultation.

A briefing paper with some questions for consideration was prepared to facilitate and provide a framework for comment (see Appendix X).

86. Interviews were carried out at the initial consultation stage, as part of the mapping exercise and during the evaluation stage with the Stroke Association. The briefing paper went out to nine user groups, following initial contact by telephone, email or post after the pilot exercise. The groups with which contact was made were as follows:

- Patients’ Forum
- Parkinson’s Disease Society
- MS Society
- Age Concern
- Carers' Association
- Chest Heart and Stroke Scotland
- Rethink
- Diabetes UK
- Cystic Fibrosis Trust.

Feedback
87. Responses were received from three of the user groups contacted. Comments received from the groups and from the initial interviews highlighted the same broad themes and are explained below.

- Outcomes-based approach
88. Respondents were positive about the holistic approach taken by the draft models. They were happy with the draft outcomes, so long as it was explicit within the explanatory notes that a patient/client perspective should be placed at the centre, particularly in terms of AHPs’ communication and team-working skills.

89. The user groups saw the approach as a way of facilitating a cultural and attitudinal shift among AHPs to achieve practice that revolves around true partnership with patients/clients. They supported the outcomes-based approach and saw reflection as key to the process. The prompt questions were viewed as central to encouraging, supporting and guiding AHPs through evaluation and reflection. The addition of prompt questions relating to cultural competence within the draft model was welcomed, but a further review was suggested to ensure the consideration of individual patient/client perspectives in all aspects of daily practice, (clinical) decision-making and service delivery.

- Communication
90. The attainment of a true partnership between patients/clients and practitioners was seen to depend crucially on effective communication and on practitioners’ ability to relate to patients/clients. User groups therefore wished to see evidence of reflection on, and evaluation of, these skills. It was
recommended that specific consideration be given to how the models could promote the need for practitioners to explain how they decide on the level, depth, format, content and consistency of their communication and how they monitor its impact and effectiveness with individual patients/clients. The need for evidence of reflection on the choice and impact of the language used was also highlighted.

- **Team-working**

91. The user groups welcomed the inclusion of collaborative working within the models’ outcomes and wished to highlight the importance of team-working skills for competent AHP practice.

- **Demonstrating effectiveness**

92. AHPs being safe and up-to-date was considered essential for the maintenance of competence. The user groups supported the models’ requirement that practitioners review their effectiveness and demonstrate changes in practice in light of feedback or new evidence. Further to this, they wished to see prompt questions that required participants to demonstrate how they gain feedback on their performance and specifically how they handle criticism; the ability to react objectively, not personally, to criticism was seen as part of being a professional (see Section 2).

- **Potential involvement in future work**

93. The groups envisaged that they could usefully be involved in the future development of the models. They suggested this could happen in the following ways:

- **Assisting in reviewing and refining the draft models,** particularly the content and wording of the prompt questions
- **Suggesting types of evidence** that could corroborate AHPs achieving concordance with their service users
- **Acting as a source of specialist information** (for example, the Stroke Association could advise on areas of which practitioners in stroke services should be aware and be incorporating into their practice and that could be used to inform expectations within any formal monitoring process)
- **Being involved in any formal verification and monitoring processes.**

**Exploring the draft models in relation to the Knowledge and Skills Framework (KSF)**

94. Specific work was done to test out how the draft outcomes models would relate to the Knowledge and Skills Framework (KSF). Originally it was hoped that an early implementer site for the KSF and a pilot site for the AHP project could be the same. However, the timing of each exercise did not coincide. Thus, after the AHP pilot exercise, one of the large multi-professional sites was invited to consider taking part in two workshops in May 2003 to explore the links between the models and the KSF. Five members of staff who had been involved in the pilot volunteered: an occupational therapist, a physiotherapist, a dietician, a speech and language therapist and a chiropodist/podiatrist. The workshops were run as a joint exercise between the AHP and the KSF projects.

95. The main aims of the workshops were to

- Test out the relationship between the draft outcomes models and the KSF
- Minimise any duplication that might arise from individuals’ use of both the models and the KSF.

96. The workshops were designed to introduce participants to the KSF, remind them of the draft outcomes models and to test the relationship out through practical exercises and debate. Discussion during the second workshop explored how reflecting on an event or incident could both support achieving the KSF dimensions for a post and demonstrate fulfilment of the outcomes within the AHP draft models, and whether this involved duplication.
While lack of familiarity with the KSF (and a need to deepen familiarity with the outcomes models), problematic timescales and the need for enhanced support for practitioners working in isolated settings were highlighted, the following positive messages emerged:

- Meeting the KSF dimensions provided a set of information/evidence that could be developed to support demonstrating fulfilment of the outcomes
- Taking a structured approach to the development of a CPD file, in particular the use of pro formas, provided the basis for meeting a variety of demands.

There was a strong level of consensus within the group. In particular, members felt that a structured portfolio should enable and support individuals to meet the requirements for a number of activities (including showing compliance with the KSF dimensions, appraisal, supervision, job applications, re-registration requirements, applications for further study) and that this would have value for individual practitioners.

One idea was to look at whether it was feasible to produce a map showing the relationship between all of the various structures and support systems of which individuals might make use. This was felt to be unrealistic, but that it was valuable to recognise that the learning cycle was a key element of most structures and schemes being developed. The use of a diagram to explain the relationship in this way was considered and agreed to be helpful (see Appendix XI). During the discussion, participants were asked to identify their ‘top tips’ for colleagues. These are listed in Box B below.

**Box B: Tips for engaging in different processes**

- Start your portfolio NOW!
- Start collecting evidence - develop the habit
- Set aside regular dedicated time
- Familiarise yourself with any frameworks you are being asked to use.

While work to explore the relationship between the draft outcomes models and the KSF involved a small number of AHPs, the group represented different professions working in a variety of roles. This allowed discussions to be very focused. Although a number of familiar messages relating to CPD were raised (for example, time and support) that could form barriers to the two initiatives, the overriding message was that the two frameworks supported one other. The key idea underpinning this was that individuals’ portfolio should provide the information and evidence needed to meet the requirements of a variety of activities, thereby reducing the need for duplication or the maintenance of separate records for developmental activities that had a different purpose or focus.

### Relationship between the draft outcomes models and the CPD framework of the Institute for Learning and Teaching (ILT)

Early on in the project, the value was identified of seeking to explore how the draft outcomes models might relate to the Institute for Learning and Teaching (ILT)’s emerging CPD framework for its members. This seemed particularly important given the intention that the outcomes models should be inclusive of AHPs working in all occupational roles, and therefore be relevant to individuals working primarily as educators in the higher educator sector.

Arrangements were made to undertake some collaborative work with the ILT in such a way that fitted with the Institute’s parallel exercise to pilot its CPD framework. Through liaison with the ILT and appropriate consultation, the University College of York and St. John was identified as an institution able and willing to engage in some joint pilot activity. Following an initial discussion, facilitated by Sheila McEwan from the AHP project and Dr. Rob Norris from the ILT, AHP representatives within the institution were invited to use the draft outcomes models relating to their profession within a slightly extended pilot period and to give feedback on how they were able to attempt simultaneously to demonstrate fulfilment of the draft outcomes and the requirements of the ILT’s CPD framework.
103. Feedback from the representatives indicated the following:

- That it was possible to draw on the same material relating to professional activity to seek to demonstrate fulfilment of both approaches
- That the format of the two approaches required material to be presented in different ways
- That it would be desirable for consideration to be given to how the requirements and format of each approach might be dovetailed to facilitate individuals' simultaneous compliance with each.

104. Within the life of the project, it has not been possible to pursue these issues further. However, it does seem clear that, should the outcomes models be implemented formally, there would be a strong merit in liaising with the ILT (in its new guise within the planned Higher Education Academy) to explore the potential to bring the two approaches closer together to streamline the effort required by AHP university educators.

Consensus-building conference
105. A consensus-building conference was held as part of the project in Birmingham on 15th May 2003. Its purpose was to

- Raise the profile of the project within and outside the participating professions
- Consider the project within a broader policy and organisational context
- Discuss the focus of recommendations that should emanate from the project
- Identify how achievements of the project could be promoted and taken forward through further collaborative activity.

106. Conference participants included representatives of the following:

- Participating professions
- Pilot site participants
- Department of Health and other UK country government organisation representatives
- The HPC
- Other regulatory bodies
- WDCs
- User groups
- Professions that have expressed an interest in the work of the project.

107. Representatives of the project Steering and Operations Groups attended, with many acting in the capacity of co-chairs, speakers and workshop facilitators.

108. Workshop sessions focused on inter-related topics. The consensus points that emerged during the plenary session are outlined in Table 3iv below. These correlate strongly with the project's underpinning thinking (see Section 2 and Annex A and the feedback gained through the pilot exercise and related consultation activities (AHP Project, 2003a).

Table 3iv: Plenary session feedback
### Accountability, inclusivity and support
- The approach needs to enable AHPs to demonstrate accountability to users
- It is essential that the approach is supportive of all AHPs – regardless of career stage, employment setting, occupational role or employment status (e.g. part-time, sessional)
- It is essential that the approach is relevant to all AHPs – regardless of career stage, employment setting, occupational role or employment status
- It is essential that the approach has equity for all AHPs, including through the development of fair, open and robust structures for verification and monitoring

### Conceptual and practical issues
- More work needs to be done to develop confidence that the approach enables AHPs to demonstrate their on-going professional competence
- It is essential that the approach is presented in a user-friendly format and includes strong elements that help AHPs to reflect on their practice
- The project presents an ideal opportunity to highlight the need for resources to enable AHPs to engage in a genuinely outcomes-focused approach to CPD

### Collaboration and difference
- There is a strong value in the collaborative approach of the project, especially within current political contexts, providing that professional differences are also recognised and respected.
Section 4: Refining the framework, models and support materials

109. The purpose of the pilot exercise was to

- Test how the draft materials were received by representatives of the AHPs
- Make inferences about how elements of the materials should be developed and refined, in light of the feedback and evaluated statements, to
  - Make them more accessible
  - Make them more useful as tools for CPD
  - Develop the models’ capacity to capture each profession’s collective sense of what makes up its competence.

The outcomes

110. Participants’ feedback, while generally not challenging directly the draft outcomes, did include comments that related strongly to them. These concerned the need for the outcomes to be developed for some professions and for their purpose and intended focus to be explained more effectively for all. Feedback particularly centred on the following:

- Queries about how fulfilment of the outcomes could be verified and monitored effectively (with it being highlighted, quite understandably, that individuals’ reflective statements and supporting evidence were not sufficient)
- Making more explicit how some of the outcomes relate to everyday practice (particularly the outcome relating to the ethical and moral dimensions of practice; outcome 3)
- Ensuring that the accompanying guidance notes make sufficiently explicit that the ‘hands-on’ or technical aspects of practice are intended to be at the heart of the outcomes (particularly outcomes 1 and 2).

111. At a more fundamental level, some participants and scrutineers within one profession (radiography) questioned whether the overall style of the outcomes-based approach could successfully relate to, or reflect, their practice as health care professionals. Such comments, echoed to a lesser extent in other professions, either explicitly, or implicitly, related to a perception that writing about practice cannot capture individuals’ actual practice. It was therefore suggested that this cast doubt on the validity of the models for providing a vehicle through which on-going competence can be demonstrated.

112. This clearly raised issues that require in-depth consideration in any further work to take the models forward. To date, discussions, particularly within radiography, have centred on a commitment to working towards a genuinely outcomes-based approach to CPD, but with the strong acknowledgement that such progress hinges on appropriate levels of support for individuals and exploring further whether such an approach to CPD can fairly and fully enable individuals to demonstrate their on-going professional competence.

113. Participant feedback on the draft models, and subsequent discussion of this, has therefore highlighted the need to

- Review whether tangible or proven links can be made through the outcomes-based approach to CPD activity and on-going professional competence - or whether a focus on demonstration of professionalism is a more appropriate goal
- Explain in different ways the project’s underpinning notions about what forms the cornerstone of professional competence; that is,
  - A critical self-awareness
  - A capacity to question and evaluate all elements of professional practice
A recognition that on-going professional development is imperative for retaining competence to ensure that knowledge and skills are maintained and extended appropriately to match individuals' (changing) scope of practice (see Section 2 and Annex A).

114. Some specific issues emerged in relation to a few of the profession-specific models, in addition to those points raised above. These issues were pursued through the profession-specific meetings convened as part of follow-up work arising from the pilot. A summary of the areas in which the need for change and development has been highlighted is given in the preface to the generic outcomes model in Annex B.
Explanatory information
115. The ways in which the outcomes were interpreted, as evidenced through participants’ statements and through their evaluation form feedback, indicated the need to be more explicit about their intended coverage and focus. In particular, the materials need to be refined to place a greater emphasis on the intention that the outcomes (particularly outcomes 1 and 2) relate to the ‘hands-on’ or technical elements of activity that are so central to many AHPs’ roles. At the same time, there is a need to review how the explanatory information can more successfully convey the intended focus of some of the other outcomes and their relevance to individuals regardless of career stage, occupational role, or employment sector or setting.

116. This particularly applied to outcome 3, as this was the outcome that was covered least well and that the greatest proportion of respondents indicated they found the least easy to relate to their professional practice (56.5% found they could relate their practice to outcome 3 compared with 74% for outcome 1 and 67% for outcomes 2 and 6). Some participants also indicated that they found it difficult to reflect on their practice from this perspective or to supply examples either of ethical or moral situations and dilemmas they encountered or how they addressed these when they arose.

117. Attempts were made in the draft explanatory notes to outcome 3 to stress the intended focus was not simply on negative experiences but rather on how individuals practise in a moral and ethical way; for example, that demonstrates their sensitivity to user need, etc., and that contributes to averting difficult situations from arising. However, there is a further need to review how this positive approach can better be promoted and how its central relevance to professional practice can be conveyed more successfully (Quallington, 2000). This will need to be done in tandem with strengthening the integration of cultural competence concepts within the materials (see below).

Support materials
- Prompt questions
118. Participant feedback generally indicated that the prompt questions were perceived as a useful tool for engaging with the outcomes and structuring statements (78% felt the prompt questions were either “Very useful” or “Useful”). In practice, while it was very easy to see how the questions had been used to structure and focus some individuals’ reflections, in others it was difficult to infer how they had been used in a systematic way or as a reference point. This, together with related issue that many of the statements lacked the depth of reflection or the forward-thinking dimensions that had been hoped for, suggested the need to consider the questions’ format and presentation.

119. One issue raised by these observations was the appropriateness of the guidance included in the draft materials that it was not necessary to address all the prompt questions directly. The intended incorporation of a new emphasis upon cultural competence within the models – and the view of the project steering group that this dimension of practice must be addressed through individuals’ response to the models – had raised further issues about the status of the prompt questions and how flexibility of usage is balanced with appropriately strong expectations and requirements.

120. Related to the above, it has been inferred that the number of questions contained within the draft models was counter-productive. Some feedback indicated that participants felt overwhelmed by the number of issues they were asked to address both under each outcome and across the outcomes as a whole. In addition, not all the questions encouraged a particularly reflective approach; while they legitimately encouraged users to review their practice and CPD to help them focus on the task in hand, they did not necessarily stimulate critical thinking. They could therefore be seen to encourage a descriptive approach from which individuals may not necessarily have progressed to genuine reflection.

121. These issues suggest the usefulness of reviewing and revising the prompt questions. In particular, there is a need to address
• Whether it is necessary to have so many questions under each outcome and whether they could be packaged differently to lessen their apparent volume
• Whether it would be beneficial to restructure the questions into introductory ones designed to focus and stimulate initial thinking and key questions that require a reflective response
• Whether these two approaches could usefully be combined
• Whether the status of some or all the questions requires review.

- Suggestions for further reading
122. Feedback on the suggestions for further reading within many of the draft models indicated that these elements were relatively little used and were not particularly welcome (45% found the suggestions “very useful” or “useful”, compared with 17% who did not find them useful and 19% who indicated that they did not use them). At the same time, where participants did draw on the kinds of materials cited (including codes of conduct or standards of practice published by their professional body), this contributed significantly to the quality and substance of what they produced and therefore the confidence that could be had in the statements. It has therefore been inferred that

• If participants had had appropriate time to draw on the referenced resources, they would have been able to strengthen their statements
• There is a need to review how references to other types of support are presented
• Consideration needs to be given to how easy it is for individuals to access related materials (e.g. those offered by their professional body).

- General guidance
Volume of material
123. The pilot materials included a large amount of information explaining the conceptual underpinnings of the approach, the structure of the draft outcomes models and expectations around how participants engaged with these. From feedback it can be concluded that participants generally felt they received too much information and that the complexity of this meant that it took some time for them to absorb key points and messages. At the same time, overall feedback did not suggest that any particular elements should be dropped. Rather, it highlighted the need to review how the materials as a whole could best be presented and to review the scope for reducing the volume of documentation.

124. There was a further need to review the sequencing and formatting of materials to make them as user-friendly and accessible as possible. In so doing, it should be borne in mind that the outcomes-based approach expounded within the materials is complex, underpinned by a sophisticated understanding of what professional practice and competence are about and a flexible, inclusive approach to appropriate forms of CPD (see Section 2). The art, as has always been recognised within the project, is to convey this complexity in as simple a way as possible. Participant feedback has indicated the need for further work to be done on this to optimise the value of the materials and to ground them more effectively in individuals’ day-to-day practice.

Supporting reflection
125. The analysis of participants’ statements showed that the areas in which statements showed the greatest scope for development were in displaying a critical, reflective approach to practice and learning and taking a forward-thinking approach to learning needs. Given these are the most challenging dimensions of the outcomes-based approach, it is not surprising that they were the least well achieved. It seems important to review how the materials can support users in these areas more effectively. It is possible to conclude that elements of the materials that encouraged such an approach were not given enough prominence and were not explained in a sufficiently simple or practical way.
126. For example, it seems likely that the checklist, included at the end of each draft outcomes model to encourage individuals to think critically about their statements, was used by very few of the participants. Its place within the materials therefore needs to be reviewed. In addition, it is not evident that the various diagrams in the introductory sections of the models emphasising the cyclical nature of the approach were referred to particularly by participants. Again, their place – and the ease with which they can be understood – needs to be reconsidered.

127. Feedback gained through the evaluation forms indicates that participants generally welcomed the Fictitious Case Scenario Pack useful (72% found it either “Very useful” or “Useful”). Where comments were made by participants on the pack’s style and content, responses were mixed. A minority indicated that they would welcome the inclusion of more examples relating to their profession. However, more feedback was gained (including through the concluding workshops) that participants welcomed the cross-professional approach and appreciated the opportunity to think more broadly about their practice by looking at examples drawn from other professions.

128. Consideration could therefore usefully be given to

- Adding to the range of examples given in the pack to reflect more fully the diversity of AHP roles and work settings
- Potentially increasing the range of styles of statements
- Perhaps expanding on the commentaries on the statements so that users are helped to gain a deeper understanding of the intended emphasis and qualities of statements.

129. Any expansion to the pack’s size would need to be based on confidence that this would enhance support to users. Again, it would need to be accompanied by a review of the materials’ presentation and format.

Integrating expectations of cultural competence

130. The British Association of Art Therapists agreed during its work to develop its draft profession-specific model that it wished to include a seventh outcome highlighting the need for its members to recognise the importance of issues relating to cultural competence. At its January 2003 meeting, the project steering group received a presentation by two members of BAAT’s art, race and culture group to stimulate discussion on making more explicit expectations around cultural competence within the project draft materials. Particular consideration was given to how this important aspect of practice could be embedded more strongly within each of the draft outcomes models (accepting that expectations were already at least implicit within each of the model’s outcomes 3 and 6 relating to ethical considerations and communication).

131. There was agreement that an approach should be pursued to integrate cultural competence into the existing outcomes within the draft models to ensure that it was strongly evident that expectations around cultural competence were mainstream within practice, rather than something marginal or separate. In keeping with this, feedback from art therapy participants within the pilot indicated a preference for the sentiments of outcome 7 to be integrated into the other outcomes, rather than its forming a stand-alone element (AHP Project, 2003a).

132. A sub-group was formed to look at the options and to report back to the steering group. The sub-group was assisted in its deliberations by information drawn together from a variety of sources and by returning to the draft common framework (see Annex B). It was not the purpose of the group to define culture or cultural competence or to prescribe how members achieved cultural competence but to define the ‘spirit’ of what should be included in the project materials.

133. The generic version of the outcomes model was used a basis for development, and each of the elements was considered separately to see how cultural competence could be embedded with the framework. Particular consideration was given to how AHPs could be encouraged to
• Explore and reflect on their own values, beliefs and perceptions and the impact of these on their interaction with patients/clients
• Recognise and value differences
• Take account of inequality and disadvantage
• Acknowledge how another person’s view of the world affects the development of a therapeutic relationship
• Explore a variety of communication avenues to inform their practice
• Explore the impact of culture on power relations
• Explore patients'/clients' expectations of health and social care, recognising that ‘culture’ plays a significant role in compliance with, and response to, treatment
• Explore and assess how their services meet the diverse needs of the population that they serve.

134. A number of amendments and additions were made to the draft generic model, particularly in the introductory section and in relation to several of the outcomes in both the underpinning explanatory note and the prompt questions to capture the above. The changes were considered and approved by the steering group and representatives of each of the participating professions. They have been incorporated within the version of the generic model attached as Annex B and it is recommended that each of the changes is incorporated into the profession-specific models as part of the refining process.

Reformatting the models and support materials
135. The pilot feedback highlighted the need to consider how the draft models and related support materials are structured and sequenced, with a view to increasing their user-friendliness and logical ordering and reducing their overall size. In particular, the evaluation of feedback and participants' statements highlighted the usefulness of reviewing the following:

- The overall emphasis within the materials on the importance of reflecting and evaluating practice and learning (including the cyclical nature of the learning process) and how support for engaging in such a process can be strengthened in practical, accessible ways (including through the integration of more tools and pro formas to help individuals engage in the process of thinking critically about their practice and learning, both retrospectively and prospectively)
- The number, status and presentation of the prompt questions to maximise individuals’ use of them while reducing their volume and apparent demand
- The best way of formatting the various elements of the support materials to optimise their logical presentation and user-friendliness; for example, by incorporating all elements of advice and expectations – including those elements that were included in the Guide for Pilot Participants - into one booklet (AHP Project, 2003b).
- The scope for developing the Fictitious Case Scenario Pack to ensure it reflects the diverse profile of professional roles across the AHPs and conveys sufficiently clear messages about how individuals should respond to the outcomes and related expectations concerning their presentation of their statements (AHP Project, 2003c).

136. Through a series of meetings between the project fieldwork officer and individual professions, discussion to date has been held on

- How the draft materials were received within the pilot (highlighting any profession-specific issues that emerged from the exercise)
- How the draft materials should be refined in light of the pilot (again, particularly focusing on any profession-specific issues)
- How professions envisaged that they might take the materials forward after the close of the project, appreciating their need for time to consider the project final report and materials in detail before being able to make appropriately informed judgements.
137. In light of these discussions and the general inferences made from the pilot exercise, work has begun to develop and refine the draft materials. Although not yet complete, evaluation of the pilot has identified clearly how the materials need to change. Information contained in the preface to the generic outcomes model in Annex B provides a summary of planned changes and developments at both collective and profession-specific levels.
Section 5: Evaluating the project’s outcomes and process

Outcomes of the project
138. The project has, to a very large extent, met its aims, objectives and intended outcomes (see Section 1) in its eighteen-month life. In particular, it has affirmed, in broad terms, that the AHPs share a common view on how they wish to move forward with CPD. This can be summarised as follows:

- A commitment to an outcomes-based approach to on-going learning and development, within which the focus is on individuals’ learning achievements and how these enhance patient/client care and service delivery (whether directly or indirectly)
- A commitment to promoting a genuinely reflective approach to learning and practice, within which, again, there is a strong focus on patient/client need and active and critical use of the professions’ growing evidence base
- A parallel recognition that pursuing such an approach to CPD has to be supported by strong support for AHPs by a range of agencies at national and local levels.

A summary of how the project’s intended outcomes have been fulfilled is presented in Table 5i below.

139. At the same time, the project forms an incomplete piece of work, in that there are several issues that require more in-depth exploration. The likelihood of this situation arising was highlighted in the project plan, particularly given the number of project partners involved and the complexity of work around which work revolved (CSP, 2001a). Areas in which this applies are highlighted in the project’s recommendations. In addition, the project has had the benefit of highlighting several areas in which it would be logical to undertake further work within a follow-on project (subject to further funding being secured) that could not have been predicted before the start of the project. Again, these are outlined in the project recommendations in Section 6.
Table 5i: Fulfilment of the project’s intended outcomes

Consideration is given in the table below as to the extent to which the project’s intended outcomes [see Section 1] have been fulfilled.

<table>
<thead>
<tr>
<th>Intended outcome</th>
<th>Fulfilled?</th>
<th>Note</th>
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</thead>
<tbody>
<tr>
<td>i. Develop a common framework and profession-specific models to demonstrate competence through CPD</td>
<td>Yes, but there is a need for further work to respond fully to the feedback received through the pilot exercise</td>
<td>Annexes A and B to the final report present the common framework and the generic outcomes model. The model requires further development and refinement, both to respond at a general level to pilot participant feedback [see Section 4 for details of planned changes] and to address profession-specific issues that have arisen both through the pilot and subsequent discussion. The prefatory paper to Annex B provides a summary of planned action from each profession’s perspective. It was highlighted in the original project plan that it was likely that refinement work on the outcomes models would not be completed within the life of the project, given the complexity of activity, the number of project partners and the tight timeframe.</td>
</tr>
<tr>
<td>ii. Produce a range of tools, developed in light of identified need, to optimise help to individuals in demonstrating competence through CPD and, in particular, assist with reflective practice, articulating learning achievements and future needs, and providing appropriate evidence to corroborate reflective statements</td>
<td>Yes, but there is a need to develop the tools further to address fully the feedback received through the pilot exercise</td>
<td>Feedback received through the pilot exercise largely supported the support tools that were developed as integral and supplementary elements of the draft outcomes models. However, there is a need to consider how these can be simplified, streamlined and presented in more attractive formats to enhance their usefulness to AHPs. In addition, the evaluation of pilot participants’ reflective statements and their feedback about the challenging nature of the outcomes-based approach, highlights the need to develop tools that more directly help individuals engage in the complex process of reflecting on their learning and practice and the relationship between the two. The value of exploring the development of such tools on a collaborative basis and, within this, of considering how materials could be produced in a web-based format, have been raised (again, see the prefatory statement within Annex B).</td>
</tr>
<tr>
<td>iii. Present an approach to demonstrating competence through CPD that has the support of the participating professions, has credibility with other</td>
<td>Yes, but the need has been identified to explore in more depth the parallel needs to strengthen support for AHPs to engage in genuine reflection and the need to explore more fully the</td>
<td>Professional bodies The project has enabled the AHPs to explore collectively the meaning and value of an outcomes-based approach to CPD. As a result, it has developed a shared commitment that such an approach is worth pursuing and that it should have at its core an emphasis on patient/client-focused care, use of the professions’ growing evidence base and</td>
</tr>
</tbody>
</table>
| stakeholders and that could provide a template for creating re-registration requirements by the HPC | relationship between CPD activity and on-going competence | reflection.  
At the same time, it is recognised that taking such an approach forward – which presents challenges for pressured health care professionals – rests on:  
- Accepting that progress will be gradual  
- Support from a range of sources at national and local levels is crucial  
- Ensuring that the approach is sufficiently grounded in individuals' day-to-day professional practice to have meaning, relevance and credibility.  

Debate around the pilot exercise has also highlighted the need for more in-depth consideration of the relationship between CPD and demonstrating competence and the extent to which an outcomes-based approach to CPD can make these links tangible. Discussions have particularly centred on ensuring that the approach is seen as relating explicitly to individuals' day-to-day practice and that consideration is given to issues of verification and monitoring.  

Involvement of user representative groups  
A particularly positive aspect of the project has been the engagement of user representative groups in activity (both through their representation on the steering group and their involvement in key consultation stages). Feedback from the groups has indicated that the outcomes-based approach to CPD, with its emphasis on the core attributes of professionalism and patient/client-focused care, has been warmly received.  

Government departments and agencies  
Although the project has been funded by the Department of Health for England, it has enjoyed a UK-wide coverage and perspective. This has been aided greatly by the representation of the Scottish, Welsh and Northern Ireland government health departments on the project steering group, as well as these representatives' active involvement at different stages of the project and advice on how the project fits with current policy initiatives in each country. The project has also been informed and placed in a wider context by the DoH's current activity to develop a post-qualifying education framework. |
The project has benefited from direct contact with workforce development confederations, again both through their representation on the steering group and ongoing contact about their activities relating to supporting AHPs’ CPD.

**The HPC**
Through the life of the project, strong links have been retained with the HPC, including through its Education & Training Committee having representation on the project steering group. This has had the benefits of ensuring that the project’s progress has been informed by developments in the HPC’s plans and thinking. At the same time, care has been taken to ensure that activity has not been inappropriately distorted by the spectre of future re-registration requirements, when the shape of these cannot yet be known. The HPC is seen as a key stakeholder and a key respondent to the project’s recommendations.

| iv. Present an approach to CPD and competence that is of prospective relevance to other health care professions and of potential application in the possible future regulation of health care support workers. | Yes – with the need, now that the project is complete, to explore ways of sharing and disseminating its findings with key stakeholders | A positive feature of activity throughout the project has been that it has generated a large amount of interest from professions and agencies that sit outside its formal remit (including those relating to pharmacy, clinical psychology, social work, teaching, medicine and accountancy). It is hoped that, through disseminating the project’s findings and recommendations, dialogue can continue.

Since the project plan was formulated, it has always been acknowledged that the approach has the potential to be customised and developed to form a useful tool for assistant staff. It is hoped that this work can be taken forward by professional bodies and others in their continuing work to strengthen learning opportunities and structures for support workers and wider policy developments relating to the potential future registration and regulation of this cadre of staff. |
Evaluating the project process

140. The success of the project has been as much to do with the process of collaboration between the participating professions as to do with what has been achieved. The project was unprecedented in forming an extended piece of work involving all the professions that come under the new Health Professions Council and in terms of being independent from any wider structure or authority (albeit with appropriate reference to key bodies and organisations, including the Allied Health Professions Forum).

141. The working arrangements between the professions have been particularly effective in the following ways:

i. The spirit of the project has been one of genuine collaboration, with this being buoyed by an enthusiasm for sharing ideas, viewpoints, experience and expertise by representatives of each profession and other organisations (including user representative groups).

ii. The subject matter of the project has provided a focus that has united the professional bodies. All recognised that the concept of demonstrating competence through CPD formed a valid and timely issue to investigate, given the need to enhance support for AHPs’ on-going learning and development and a keenness to seek an appropriate influence over how re-registration requirements are developed and implemented in the future.

iii. The spirit of collaboration has meant that the sum of what it has been possible to achieve was above and beyond what any of the individual professional bodies could have achieved alone. For example, it was through the process of developing a common framework within which profession-specific work was undertaken that enabled ideas from individual professions to be shared with others, with mutual benefits arising as a result.

iv. The project allowed economies of scale that meant it was possible for more to be achieved than would have been the case had the same work been tackled by professions in isolation. The significance of this was increased by the substantially different size of the professions involved, with the project affording opportunities for exploration that would simply not have been possible for small organisations working alone. For all, the work would not have been possible without securing external funding.

v. The project provided a useful context in which different perceptions and views within the professions could be aired and explored in constructive ways. Inevitable differences of view on certain points proved positive in stimulating thinking and the re-evaluation of perspectives, again within an overall context in which participating professions shared a sense of common goal and purpose.

vi. The cross-professional approach to work has resonated well with the increasing trend for AHPs to practise within multi-professional teams; to develop an approach that has shared characteristics across the participating professions can only be beneficial if the models are to be implemented formally, since the approach reflects the realities of the workplace.

142. While the project enjoyed many positive features, issues inevitably arose form which lessons can be learned. These should inform any future work emanating from the exercise, or future collaborative work that focuses on wholly different topics. Particular areas in which lessons can be learned are outlined below.

Timeframe

- The project was set within a tight timeframe. While the schedule for completing individual stages was met, the timescale did create some highly pressured points. Feedback from pilot participants highlighted that the timescale set for testing the materials was too short (not helped by its timing within the calendar year). In addition,
a more relaxed timescale at key developmental stages (especially in the closing stages of work) would have allowed for more sharing of thinking and ideas across the participating professions and allowed for wider consultation.

Capacity

- While the project was supported by a project team of four, only one member of the team undertook project activity on a full-time basis, with two others managing and contributing to the project as part of broader workloads. Any further project work would need to be supported by a team with a greater capacity to devote time to activity (including, potentially, the creation of flexible arrangements that would enable the team to be expanded at particularly busy points).

Networking

- The project benefited from a strong spirit of collaboration between the participating professions. On a practical level, this was greatly aided by the project operations group meeting frequently throughout the project’s life (see Section 1). However, the benefits of this group could have been enhanced by formalising opportunities for more regular networking (for example, through the creation of an email group). This would enable more contact between professions, as well as the strong communication that took place between the project team and the individual professions.
Section 6: The project’s recommendations

143. There is a keenness on the part of those who have been involved in the project that its outcomes are taken forward in tangible ways, at both national and local levels, not least because of the huge amounts of time, effort and commitment that each profession has put into the project and the investment in activity by the Department of Health. At the same time, there is a recognised need to be sensitive to different bodies’ perspectives, priorities and broader schedules.

144. The project recommendations recognise that participating professions and other stakeholders will need to give careful consideration to the issues emerging from the project. At the same time, the recommendations are designed actively to promote the adoption of the models and support materials as a possible approach to future re-registration requirements and as a way of enhancing support for AHPs’ on-going learning and development. In particular,

- Professional bodies are encouraged to consider how the outcomes of the project relate to existing policies on, and support for, the CPD of their members
- Employers, fundholders, government departments, professional bodies and the HPC are encouraged to consider how the AHPs can better be supported to engage in an approach to CPD that requires them to engage in a process of genuine reflection and a planned, structured approach to their on-going learning and development.

145. The above could be done partly through the possibility of further commissioned work. However, there is also strong scope for exploring how the project products can be used to complement and enhance existing structures, schemes and tools for CPD and professional competence and related structures (including appraisal, clinical supervision, mentorship and personal development planning).

146. The project recommendations are presented in Table 6i below, with indications given of the key target audiences for each recommendation, together with an explanatory note.
### Table 6i: Project recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Explanatory note</th>
<th>Target audience(s)</th>
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</table>
| **1. An outcomes-based approach to CPD activity should be adopted**, within which the focus is on individuals taking a structured, evaluated approach to their learning, with heavy consideration given to learning achievements, how these are applied in practice and the resulting benefits for patient/client care and service delivery (whether directly or indirectly). | The recommendation acknowledges that the participating professions are at varying stages in promoting and adopting an outcomes-based approach to CPD and that meaningful action in taking the approach forward rests on its being  
  - Integrated with current schemes, tools and initiatives at national and local levels  
  - Supported in ways that are sensitive to the particular profile, setting and needs of each profession.  
  - Professional bodies  
  - Health Professions Council [HPC]  
  - Allied Health Professions Forum [AHPF]  
  - UK government health departments  
  - Education commissioners [including WDCs]  
  - Employers  
  - Higher education institutions [HEIs] and other supporters and providers of CPD opportunities | All major stakeholders; i.e.  
  - Professional bodies  
  - HPC  
  - AHPF  
  - UK government health departments  
  - Education commissioners  
  - Employers  
  - HEIs and other supporters and providers of CPD opportunities |
| **2. The common framework developed within the project should be adopted**, with careful consideration given to the implementation of its key principles and the implications of this for AHPs’ practice and learning | The common framework, attached to the report as Annex A, sets out a range of principles relating to CPD and competence. Of particular significance are its statements on  
  - An outcomes-based approach  
  - Scope of practice  
  - Professionalism  
  - Competence  
  - Taking a patient/client-centred approach to practice  
  - Embedding an understanding of, and sensitivity to, issues of cultural diversity within practice  
  - Promoting inter-professional collaboration in the interests of patients/clients.  
  - Professional bodies  
  - HPC  
  - AHPF  
  - UK government health departments  
  - Education commissioners  
  - Employers  
  - HEIs and other supporters and providers of CPD opportunities | All major stakeholders; i.e.  
  - Professional bodies  
  - HPC  
  - AHPF  
  - UK government health departments  
  - Education commissioners  
  - Employers  
  - HEIs and other supporters and providers of CPD opportunities |
| **3. The generic outcomes model should be adopted as the basis for the further development and refinement of profession-specific models**, with careful consideration given | The generic outcomes model is attached to the report as Annex B. It is prefaced by an explanation of the modifications and developments identified to date through profession-  
  - Professional bodies  
  - AHPF | All major stakeholders; i.e.  
  - Professional bodies  
  - HPC  
  - AHPF  
  - UK government health departments  
  - Education commissioners  
  - Employers  
  - HEIs and other supporters and providers of CPD opportunities |
Section 4 of the report explains the general changes planned in light of pilot participant feedback. For example, the pilot exercise indicated the need for the materials to be made more user-friendly (including through simplifying the language used) and reduced in size. It also indicated the need to review how the materials can best be packaged to provide guidance in the most logical sequence.

The pilot also highlighted the need to address calls for the materials to relate more explicitly to individuals’ day-to-day practice and, in particular, to encapsulate more overtly the technical, hands-on elements of practice that are central to the activity of many AHPs.

Work has already been undertaken to indicate the importance of AHPs understanding, and being sensitive to, cultural diversity issues in their everyday practice within the generic outcomes model [Annex B]. This could valuably be taken further, including through planned work to refine the profession-specific models, to ensure that this facet of practice is given due prominence and has the desired impact of raising awareness, understanding and changing practice, as appropriate.

5. Feedback received from user representative groups should be used to inform the development of the models to ensure they convey sufficiently strongly the intention that individuals demonstrate how they engage in a patient/client-centred approach to care (whether directly or indirectly), while consideration should be given to how a user perspective can be sought and used to inform future developments and initiatives in related/other areas.

The involvement of user representative groups within the project, both through their formal representation on the steering group and through their being consulted at key project stages, has been very positive. The contacts that have been made - and the strong interest and support for the project’s approach that have emerged through this contact – could valuably be drawn on in follow-up activity and any subsequent initiatives, including any moves to implement the models on a formal basis.

It is recognised that the emphasis placed on a patient/client-centred approach to care should correlate with the level and
type of patient/client contact that is typical within the practice of each profession. There must therefore be an acknowledgement of how engagement with a patient-/client-centred approach is manifested in different ways within different occupational roles.

### 6. Any future project activity should include an in-depth exploration of how the outcomes models and accompanying support materials can best be presented, including through their production in more imaginative and creative formats and their production as web-based materials, as well as in hardcopy format.

Development of the materials should take account of the limitations of the present project’s pilot exercise. In particular, there would be a need to address:

- The shortfalls in the geographical spread of pilot sites
- The wide variety of response rates within the different professions
- Possible differences in how AHPs practising in different occupational roles relate to the models.

The above work should be accompanied by consideration of how the materials need to be developed and customised at a profession-specific level to ensure they best relate to needs and profile of each profession [see Recommendation 3].

### 7. Consideration should be given to how the project materials can best be promoted and used.

This needs to be done with a view to complementing and strengthening existing approaches to CPD and professional competence and recognising the need for AHPs to receive appropriate forms of support for their on-going learning and development. This is especially important if practitioners are to be enabled to engage in a genuinely structured and reflective approach to their learning.

There is also the scope for considering how the approach and outcomes of the project:

- Could usefully inform a broader range of activity relating to the support of professional practice (including work around standard-setting and achieving a stronger commitment to evidence-based health care)
- Could usefully be adapted for use with assistant level

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<th>Professional bodies</th>
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<tr>
<td>Education commissioners</td>
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<td>HPC</td>
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<tr>
<td>HEIs and other supporters and providers of CPD opportunities</td>
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8. Consideration should be given to using and promoting the thinking and approach that the project has developed to professional competence, while recognising that more work needs to be done to explore how such an approach correlates with individuals’ on-going learning activity.

The project has developed basic principles relating to professional competence [see Section 2 of this report, along with Annex A]. At the same time, the pilot exercise has not indicated unequivocally that the draft outcomes models enable individuals to demonstrate their on-going competence through CPD.

There is a need to explore

- How more explicit indications can be given within the models that they are intended to relate to hands-on, skills-based elements of activity that are fundamental to AHPs’ day-to-day practice
- Whether the development of appropriately robust, yet flexible, arrangements for verifying and monitoring individuals’ engagement with the outcomes models could deepen confidence that tangible and demonstrable links between learning activity can be made.

9. Consideration should be given to how AHPs are more fully supported and enabled to engage in an outcomes-based approach to CPD in ways that complement existing initiatives to enhance learning and development and optimise the quality of patient/client care and service delivery.

The project has highlighted that, if an outcomes-based approach to CPD is genuinely to be pursued (implying the adoption of a planned, structured, reflective and evaluative approach to learning), AHPs need enhanced support in the form of time, resources and guidance (particularly on reflecting on practice and learning and articulating learning needs and achievements). It is important that these needs are acknowledged and addressed by all employers.

Initiatives to enhance support could logically and usefully be pursued on a cross-professional basis, enabling the sharing of expertise and experience and economies of scale.

<table>
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<th>Staff</th>
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<td>• Be promoted and disseminated to a broader audience (including other professional groups within and outside health and social care).</td>
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<tr>
<td>• UK government health departments</td>
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<tr>
<td>• HEIs and other supporters and providers of CPD opportunities</td>
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</table>
10. Any further project work emanating from current activity should have, as a central focus, the development of robust, yet flexible, processes through which individuals’ compliance with the outcomes models could be verified and monitored, with this work informed by developments relating to the HPC’s introduction of future re-registration requirements.

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<tr>
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While issues of verification and monitoring lay outside the scope of the current project, how the approach can be bolstered by appropriate mechanisms and systems has formed a central point of debate throughout the project’s life, as well as forming a strong topic of feedback from pilot participants.

It therefore seems a logical next step to explore this complex issue, accepting that the formal implementation of the approach would rest on developing robust, yet flexible, systems in which all stakeholders could have confidence and credibility.

11. Any future project work should draw on lessons from the project, both in terms of the wealth of data that has been generated from activity and issues that have arisen regarding the process.

The project has formed an unprecedented exercise in bringing all the AHPs together to undertake a large-scale piece of work in which there is a strong common interest. It offers a model to emulate, while also highlighting lessons that could usefully be learned from in any subsequent cross-professional activity. These are highlighted in Section 5 of the report.

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<th>AHPF</th>
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<th>UK government health departments</th>
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12. The strong merits of the project’s collaborative approach should be acknowledged, with particular consideration given to how its spirit, arrangements and methodology could be used to inform activities in other topic areas.

See above

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<tr>
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<th>HPC</th>
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13. The project’s findings should be disseminated widely, recognising the strong levels of interest that its approach and activities have generated.

Throughout the life of the project, interest in its aims and activities has been very strong, both within and well beyond the AHPs and health and social care. It has also attracted interest from a wide range of types of organisations, including from other professional bodies (including at an international level), regulatory bodies other than the HPC, research-based policy organisations, training organisations, employers and education commissioners.

The approach of the project is seen as genuinely innovative in its approach to CPD and seeking to make the links between

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14. The project’s findings should be used to identify further areas that could usefully be explored, particularly given the wealth of data it has gathered about AHPs’ engagement with, and views on, CPD and demonstrating on-going professional competence.

While the latter stages of the project have been concerned with analysing the data gathered through the pilot exercise to inform the development of conclusions and recommendations, it remains that there is scope for interrogating and using this data further.

There is also the scope for identifying issues raised by the project’s findings that could valuably be explored in more depth. These include enhancing support for AHPs’ CPD and pursuing the significance of different needs and priorities relating to varying career stages, occupational roles and employment sectors and settings.

| • Professional bodies  
| • AHPF  
| • UK government health departments  
| • Employers  
| • Education commissioners  
| • HEIs and other providers and supporters of CPD opportunities |
Section 7: Summary and conclusions

147. The project has succeeded in fulfilling its aims, objectives and intended outcomes. It has affirmed that the AHPs share a broadly common view on how they wish to move forward with CPD. Within project activity, it has been possible to optimise this, while recognising and respecting the different professions’ particular profiles, priorities and current approaches to CPD. The overarching messages of the project can be summarised as follows:

- A shared commitment to an outcomes-based approach to on-going learning and development, within which the focus is on individuals’ learning achievements and how these enhance patient/client care and service delivery (whether directly or indirectly)
- A shared commitment to promoting a genuinely reflective approach to learning and practice, within which, again, there is a strong focus on patient/client need and active and critical use of the professions’ growing evidence base
- A parallel recognition that pursuing such an approach to CPD depends heavily on support from a range of agencies at national and local levels and that its implementation can only be taken forward successfully on an incremental basis.

148. There is short-term work to be done to conclude the refinement of the outcomes models and support materials, as was identified would be a possibility in the original project plan (AHP Project, 2001). In addition, the project has highlighted the scope for further work to be done to take the outcomes-based approach to CPD further forward, including to the point of formal implementation.

149. The primary areas in which further work could valuably be done, subject to further funding being secured, are as follows:

- More in-depth exploration of the relationship between competence and CPD and how this can be demonstrated at an individual level through the development of the outcomes models
- The development of robust, yet flexible, arrangements for verifying and monitoring individuals’ engagement with the outcomes models that can inspire confidence within and outside the professions while adding to the value of the models as a tool for individuals’ professional development
- The development of the materials in more user-friendly, accessible formats, including as a web-based package
- The strengthening of support for AHPs (in terms of time, resources and access to education and guidance) to enable them to engage in a genuinely reflective, structured approach to their CPD.

150. It is essential that such work is taken forward with strong reference to the HPC’s exploration of the development of future re-registration requirements and to initiatives relating to CPD, the quality agenda, professional competence and cross-professional practice in each of the UK countries.

151. Key to the project’s success has been that the professions have worked together collectively. This has been underpinned by a genuine spirit of collaboration, together with a mutual respect for, and recognition of, professional difference. Such an approach, including the practical arrangements for the project, could valuably inform activity among and beyond the AHPs in other subject areas.

Dr. Sally Gosling, with contributions from Dawn Wheeler and Sheila McEwan
13 August, 2003
Acknowledgements

Thanks are due to the following in contributing to the project:

**Project steering group**
Ken Andrew – British Association of Prosthetists and Orthotists
David Ashcroft – Society of Chiropodists and Podiatrists
Martin Cody – British Association of Art Therapists
Stephen Dolphin – British Paramedic Association
Kamini Gadhok – Royal College of Speech and Language Therapists / Allied Health Professions Forum
Alison Geddis – Institute of Biomedical Science
Mary Gilbert – Welsh Assembly Government
Mike Hallworth – Association of Clinical Scientists
Suzanne Henwood – Society and College of Radiographers
Fiona Hodkinson – Department of Health, Social Services and Public Safety, Northern Ireland
Gillian Jordan – Chartered Society of Physiotherapy
Richard Lane – British Paramedic Association
Jacqui Lunday – Scottish Executive
Dr Wendy Magee - Association of Professional Music Therapists [chair]
Mary Cousins - General Social Care Council
Elizabeth O'Flynn – British Orthoptic Society
Gillian Pearson – Health Professions Council
David Pilling – General Medical Council
David Powley – British Association of Dramatherapists
Rosemarie Simpson – British Dietetic Association
Julia Skelton – College of Occupational Therapists [vice-chair]
Pam Turpin – Patients’ Forum / RNIB
Caroline Waterworth – workforce development confederation representative
Maureen Williamson – Nursing and Midwifery Council
Filao Wilson – Department of Health

**Alternates**
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Vinette Cross – Chartered Society of Physiotherapy
Anne Gilford – workforce development confederation representative
Ethna Glean – Society and College of Radiographers
Tony Hazell – Health Professions Council
Graham Ixer – General Social Care Council
Sean Kelly – Society and College of Radiographers
Prue Kiddie – Department of Health
Anne Lawson-Porter – College of Occupational Therapists
Jacky Nolan – British Orthoptic Society
Priya Rasanayagam - Institute of Biomedical Science
Bronwen Roberts - workforce development confederation representative
Gordon Sutehall - Institute of Biomedical Science [Jan 2002 – December 2002]
Taravandana - workforce development confederation representative

**Project operations group**
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Mark Broomfield – British Association of Prosthetists and Orthotists
Martin Cody - British Association of Art Therapists
Sean Kelly – Society of Radiographers
Richard Lane – British Paramedic Association
Anne Lawson-Porter – College of Occupational Therapists [Mar.-Jun.2003]
Dr Wendy Magee - Association of Professional Music Therapists
Jacky Nolan – British Orthoptic Society
Elizabeth O’Flynn – British Orthoptic Society
The Department of Health for funding the project and advising on its direction and context within broader policy initiatives

Participating professional bodies for supporting the project in numerous ways, including through representation on the project steering and operations groups, shaping the development and refinement of the draft profession-specific outcomes models, carrying regular publicity and updates on the project in their respective bulletins and magazines and hosting project meetings

Pilot site participants for investing time and energy in testing out the draft project materials and providing detailed feedback on their participants and for hosting induction and concluding workshops

Scrutineers from each of the professions for assisting with the evaluation of the pilot exercise

User involvement group representatives for giving feedback on project proposals and draft materials at key stages of activity

Participants in the consensus-building conference for sharing ideas and views on what the project had achieved and how it could usefully go forward

Gillian Rose from the NHS Modernisation Agency and Dr. Rob Norris from the Institute for Learning and Teaching [ILT] for engaging in joint working to explore the relationship between the draft outcomes models and the Knowledge & Skills Framework and the ILT’s CPD framework respectively

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Introduction
This document forms the common framework that rehearses the principles and underlying thinking of the AHP project on demonstrating competence through CPD.

In preparing the original version of the framework (approved by the project steering group in April 2002 as a working document), information was drawn from the project’s initial mapping and consultation exercise, background thinking and discussions that took place at a workshop in March 2002. It has since been developed and refined, taking account of the evaluation of the pilot exercise, input from user representative groups, the development of collective thinking within the project on cultural competence, the consensus-building conference and the steering group’s concluding discussions.

The development of the framework was informed by the project’s broader context, primarily:

- Government initiatives in each of the UK countries to enhance patient/client care and service delivery and related initiatives around CPD and lifelong learning (BRI, 2001; DoH, 2000a; DoH, 2000b; DoH, 2001; DHSSPS, 2001; Nat.Ass.Wales, 2001; Sc.Exec., 2000)
- Knowledge that the new Health Professions Council [HPC] will introduce re-registration requirements in the future as part of its development of new regulatory structures and processes to strengthen the AHPs’ public accountability (HPC, 2002; HPC, 2003).

The project began from the premise that future re-registration requirements need to recognise the complexities of practice, be inclusive of all members regardless of occupational role, career stage and employment sector, and simultaneously fulfill the primary purpose of protecting the public and the parallel aim of forming a process that has positive benefits for AHPs’ learning and development.

The project has also sought to balance:

- Recognising AHPs’ responsibility for their own professional development and maintaining competence

with

- The importance of employers enabling staff to maintain – and extend – their competence through providing appropriate support for, and provision, of learning opportunities to enhance service delivery and address issues of staff recruitment and retention (accepting that not all AHPs are employed).

The framework comprises the following sections:

- Underlying concepts
- Underpinning principles
- An explanation of the key elements of profession-specific outcomes models.

Together with the generic outcomes model [see Annex B], the common framework formed the starting-point for developing draft profession-specific models.
Underlying concepts

• **Professionalism**
  Key to the project’s approach to demonstrating competence is the concept of professionalism. This reflects the AHPs’ underlying values and thinking, the complexities of practice, and the privileges and responsibilities that professional practice confers. These values can be summarised as follows:
  
  • A motivation to deliver a service to others
  • Adherence to a moral and ethical code
  • Striving for excellence, maintaining an awareness of limitations and scope of practice and demonstrating this
  • The empowerment of individuals and teams (Hodkinson, 1995; Medical Professionalism Project, 2002).

• **Professional competence**
  Fundamental to the notion of professionalism is that of competence. This can be seen as encompassing
  
  • A responsibility to ensure the safety and efficacy of practice
  • An ability to think critically about practice, learn from this and apply the learning to subsequent professional activity
  • A recognition that competence does not exist in a vacuum but is affected by individuals’ interaction with others and the context in which they work
  • A recognition that competence - and therefore scope of practice - develops over time
  • An ability to deal with the new and non-routine.

• **Scope of practice**
  Integral to developing a sound notion of professional practice is accepting the importance of scope of practice. Within the AHPs’ codes of conduct and standards of practice, clear reference is made to individuals’ responsibility to limit their practice to those areas in which they have established and maintained their competence (Wheeler, 2002). This requires individuals to maintain an awareness of their scope of practice by engaging in on-going reflection and evaluation about how and why it has changed and how it needs to change in response to changing demands and planned career moves.

  The on-going development of underpinning knowledge and skills should be incorporated into this process. While newly-qualified practitioners have a professional grounding and set of core knowledge and skills on qualification, this will be built on during their career. Likewise, someone returning to practice after a break may need additional support and supervision to work safely and effectively.

  Individuals’ competence therefore varies according to their career stage, professional experience, occupational role and employment sector and setting. Although how individuals describe their competence may be different, they should be able to demonstrate their adherence to broad notions of professionalism and competence, since the underlying attributes of their practice should be similar. It therefore follows that any description of competence should be sufficiently broad and flexible to allow its application across the whole of a profession.

  Codes of conduct and standards of practice form the professional context within which members of the AHPs are expected to work and set out the ethical and moral frameworks for individuals’ practice. Key elements can be summarised as follows:
  
  • Central to practice is a duty of care, which incorporates safety and efficacy of practice, the autonomy of the patient/client and the need for services to be patient/client-focused
  • Exercising personal and professional integrity
  • Maintaining competence and working within scope of practice
  • Collaborating and communicating with others to the benefit of the patient/client
• Maintaining accurate records and documentation in line with relevant protocols and legislation.

• **User perspective**
  The importance of the above elements is further supported by feedback from user representative groups consulted during the project. The groups indicated their strong support for an approach to CPD that

  • Emphasises the centrality of the patient/client perspective
  • Recognises the need for health care professionals to communicate effectively and with sensitivity to individual need
  • Sees reflection as vital to the process of engaging in genuine partnership
  • Focuses on effective, up-to-date practice
  • Revolves around professionals working within the scope of their practice.

• **CPD**
  While it is generally recognised that there is a link between CPD and competence, demonstrating this link in tangible ways is not straightforward. This, in part, relates to individuals’ approach to CPD. In the past, this has tended to be defined by, for example the number of external courses undertaken. A cultural shift is required if individuals are to identify and acknowledge the

  • Wide range of learning needs they are likely to have
  • Diverse learning opportunities available to them (including work-based learning)
  • Centrality of reflection to a planned, structured approach to learning.

The professional bodies are working with their members to help them make this change and recognise and utilise the structures that are currently in place (Wheeler, 2002). Supervision in its various forms is a key way in which reflection and evaluation of learning needs, outcomes and achievements can be supported, alongside appraisal systems where these are in place.

An approach to CPD that encourages and supports individuals to plan, structure and reflect on their learning should help them to achieve and demonstrate the links between their on-going learning and development and their competence. Individuals’ ability to reflect on the systems, procedures and context in which they work is also important. It is recognised that, while individuals are responsible for driving this process, employers have a crucial role to play in providing appropriate forms of support.

The project has defined the following approach to CPD, informed by materials provided by the professions during the initial mapping exercise:

*CPD should be a systematic, on-going, structured process of maintaining professional development by*

  • Promoting reflection, both individually and within teams
  • Promoting the identification and recognition of the wide variety of ways in which individuals can learn (accepting that individuals have different learning styles and needs)
  • Actively assessing learning needs, identifying learning outcomes, formulating plans to meet needs, evaluating activity and re-starting the cycle.

*The key outcomes of CPD activity should be*

  • The application of learning to practice
  • Continued competence to practise
  • Meeting the needs of the patient/client and the service (whether directly or indirectly).

• **An outcomes-based approach**
An outcomes-based approach to demonstrating competence through CPD takes an holistic view of competence by identifying a series of outcomes, which describe in broad terms the attributes that professionals should be able to demonstrate. This approach is seen as recognising

- The diversity and complexity of practice
- The changing and evolving nature of practice for individuals and their respective profession
- The wide variety of roles and settings in which members of the AHPs work.

Use of outcomes should provide a structure through which individuals can demonstrate their commitment to a systematic, evaluative approach to CPD and, in turn, provide evidence of their continuing competence.

The emphasis of the approach is on individuals and their interaction with the world in which they practise. This means that they are expected to take responsibility for identifying their learning needs, developing a plan to meet these, evaluating its progress and identifying new needs as appropriate, with appropriate support from others. Part of the nature of such an approach to learning is that it is not done in isolation but within the context in which the individual is practising, with use made of supervision, coaching, mentoring, appraisal systems, peer review, team colleagues and any other systems that allow discussion and feedback, as well as self-assessment. Central is the ability to reflect on practice, learn from this and apply learning critically to subsequent professional activity.

‘Behaviourist’ or ‘technical-rational’ approaches to competence can be seen as more practical and easily measurable, as well as to relating more obviously to the immediate demands of day-to-day practice, than an outcomes-based approach. However, they carry the danger of undermining the fundamental and core attributes of what it means to be a professional (see above). They also tend to be based on inputs rather than outputs and often place an undue emphasis on course attendance (Ashworth & Saxton, 1990; Ashworth, 1992; Gonczi, 1994; Hodkinson & Issit, 1995; Hyland, 1995).

- Cultural competence

The context and diversity of the community that professionals serve forms an important element of individuals’ competence. The evaluation of practice needs to take into account the impact of AHPs’ own values, attitudes and assumptions as well as those of the people with whom they work. This requires

- Self-awareness and understanding on the part of practitioners
- Recognition of the impact that culture has on individuals’ perception of the world, health and illness
- A commitment to incorporate this knowledge and approach within practice.

Underpinning principles

The underpinning principles rehearsed below are central to the draft profession-specific models [see Annex B]. They are firmly rooted within the AHPs’ codes of conduct and standards of practice. In formulating the principles, account was taken of the following:

- Background thinking to the project (CSP, 2000; CSP, 2001; Gosling, 1999)
- The baseline report and linked material (Wheeler, 2002; Williamson, 2001)
- Preparatory information for the March 2002 workshop (Gosling, 2002)
- Group discussions at the March 2002 workshop
- Discussions on cultural diversity and cultural competence within the project (Wheeler, 2003)
- Feedback gained through user involvement in the project
- Feedback gained through the project’s consensus-building conference.

Each of the principles carries equal weighting. Inevitably, there is some overlap between some of them. This reflects the inter-related nature of the concepts they represent.
1. The broad attributes of professional practice, together with its complexity, must be recognised.

Explanatory note
This acknowledges that professional practice is diverse and that an holistic approach to competence is more helpful than one that constrains individuals or the profession to which they belong by undue prescription. It recognises that the fundamental and core attributes of being a professional are applicable to all within a profession, regardless of career stage, occupational role, or employment sector or setting.

2. The ethical and emotional dimensions of professional practice must be recognised.

Explanatory note
This encompasses a profession’s underlying values and thinking and recognises the centrality of this to professional competence, the privileges of autonomy and self-regulation that being a member of a profession confers and the accountability of professionals to the individuals they serve.

3. The impact of self on practice and how other people view the world must be recognised.

Explanatory note
The diverse needs of the community served need to be recognised and respected, acknowledging that individuals’ perceptions of health and illness are influenced by cultural beliefs. Individual professionals also need to recognise the impact of their own attitudes, assumptions and beliefs on their practice and that their practice must sit within, and accord with, all relevant legislation. Within contemporary health and social care, it is essential that AHPs’ practice and learning take account of issues of diversity and equality.

4. There must be a strong emphasis on professional trust and self-evaluation, while ensuring safety and effectiveness are upheld.

Explanatory note
Individual professionals have a responsibility to ensure the safety and efficacy of their practice by ensuring that that they place the patient/client at the centre of their practice, reflect on their practice, acknowledge their limitations and act accordingly.

5. The dynamic relationship between individuals’ scope of practice and that of the profession to which they belong must be recognised.

Explanatory note
Individuals’ scope of practice develops and changes over time and depends on a variety of factors, including the development of the profession to which they belong and their own changing professional role and career progression. This, in turn, is affected by the global context in which the profession operates, including changing patient/client need and shifts in health and social care policy, organisation and structures.

6. Conceptions of competence must be inclusive of all members of a profession.
Explanatory note
An approach needs to be sufficiently broad and non-prescriptive to take account of the diversity of roles and contexts in which AHPs work, regardless of career stage, occupational role and employment sector and setting.

7. Individuals’ responsibility for their competence must be promoted, while recognising the broad range of factors that impact on this.

Explanatory note
While it is individuals’ responsibility to recognise the scope of their practice and to maintain and develop this, their ability to do this is affected by the context in which they work and by their receiving appropriate levels of support to address on-going learning and development needs.

8. The dynamic relationship between learning and practice must be recognised and promoted.

Explanatory note
The ability to reflect on practice, learn from this and apply new learning to practice is central to the project’s approach to CPD. It needs to be seen as an on-going process and one grounded in everyday practice. Knowledge and skills _per se_ are not sufficient; they need to be evaluated critically and applied in ways that deliver a safe effective service, with individuals demonstrating the capacity to deal with the new and the non-routine.

9. There must be recognition that individuals’ competence does not exist in a vacuum.

Explanatory note
Effective communication and collaboration with others are essential elements of safe, effective practice. Individuals therefore need to be able to interact within the contexts in which they work to perform competently.

10. The importance of working towards a true partnership and concordance with patients/clients must be recognised.

Explanatory note
The ability to place the patient/client at the centre and understand their perspective is critical to ensuring that they can engage with their treatment and the services offered and therefore ensure effective use of resources.

11. Recognition must be given to the importance of communication and collaboration.

Explanatory note
The ability to communicate and collaborate appropriately are key skills for working with patients/clients/careers and in multi-professional teams. The inter-disciplinary nature of most professionals’ work means these skills are core to the delivery of effective care and services (whether directly or indirectly).
Relationship between the framework and the profession-specific models

The common framework sets out the shared thinking and underpinning principles that set the parameters for the profession-specific models. Within this, there is scope for each profession to incorporate nuances related to their profession and the tools that they currently have relating to CPD and competence.

While it is possible that this process may identify the merits of reviewing and developing tools already in place, the project has not sought to replace schemes that the individual AHPs already have.

The common framework is presented essentially as a reference document. It is expected that individual members of the AHPs will engage primarily with the draft profession-specific models, referring to the common framework as appropriate, rather than the document forming the primary vehicle for the approach.

Key elements of the profession-specific models.

The underlying concepts, underpinned by each profession’s codes of conduct and standards of practice, along with the principles identified above have informed the process of developing profession-specific models. The models’ key elements are illustrated in the diagram below.
It was agreed that each profession-specific model, as well as including the elements illustrated above would include the following:

- A brief introduction to explain the purpose and structure of the model
- A number of outcomes which describe:
  - in broad terms the attributes, that a member of the profession in question, should be able to demonstrate
  - are inclusive of the whole profession
  - reflect the changing nature of practice both individually and within the profession
- Each outcome to be underpinned by:
  - an explanation of its significance and the key concepts on which it is based
  - prompt questions to help the member begin to formulate their ideas on how the outcomes relate to their practice and what kinds of evidence might be appropriate
  - suggestions on how to demonstrate fulfilment of the outcomes, which could include the use of case scenarios or other appropriate examples
  - reference to professional material and or other sources of support that may be useful (to include advice on where to access material)
- Consideration and or reference made to specific tools available within the profession and how they might link with the outcomes and or model in general.

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DRAFT VERSION incorporating additional elements relating to diversity

AHP project: Demonstrating competence through CPD

Draft Outcomes Model [generic version]

August 2003
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DEMONSTRATING COMPETENCE THROUGH EVIDENCE OF CONTINUING PROFESSIONAL DEVELOPMENT.

Introduction
The outcomes model has been designed to help you demonstrate your continuing competence through providing evidence of your continuing professional development (CPD). In so doing, it is intended to assist you in preparing for future re-registration requirements. The creation of the Health Professions Council and the anticipated introduction of statutory re-registration requirements mean that individuals will need to provide evidence of CPD that confirms their continuing competence to practise.

The precise nature of future re-registration requirements is unclear. The model should help you demonstrate the benefits of your learning for patient care (in whatever capacity you work) within broad quality agendas, including clinical governance. The model has been adapted from a draft outcomes model originally developed by the Chartered Society of Physiotherapy for its members.

The starting point
The model is based on the assumptions that learning should be career-long and that applying learning to practice – and identifying what you have learned through practice – is a cyclical process that is central to remaining competent. This is illustrated in the diagram below [Diagram 1].

Diagram 1: On-going professional competence

The process of reflecting on, and evaluating your professional practice and development is not a simple one. The model is designed to provide a structure for the evaluation of your on-going professional development and to help you demonstrate your professional competence within your specific scope of practice.
The outcomes
The six outcomes describe professional competence in broad terms, while providing a structure to help you plan, undertake and review your CPD.

The outcomes are that, as a ……………. you should be able to

1. Understand, work within and respond appropriately to the limits of professional practice;
2. Demonstrate effectiveness in practice;
3. Practise within your profession’s moral and ethical framework;
4. Think critically about personal practice and its context;
5. Deal appropriately with the new and non-routine;
6. Communicate and collaborate effectively.

The outcomes reflect

• The complexities of professional practice;
• The diverse roles and settings in which allied health professionals work;
• The changing nature both of your personal professional practice and that of your profession as a whole.

It is expected that, in considering each of the outcomes, you think about the context in which you work and the diversity of the community you serve. Part of evaluating your practice means considering how you engage with others, including examining the impact of the assumptions, attitudes and values that underpin your practice.

Your attention is drawn to the relevant legislation as follows:

Outcomes one and two relate to the range and quality of your practice and highlight that safety and effectiveness lie at the core of professional competence. Outcomes three to six describe additional, crucial dimensions of professional practice.

Material provided with each outcome
The model should be easy to understand and apply to your professional practice. Each outcome is supported by:

a) an explanatory note which gives more detail about the outcome and what it covers;
b) prompt questions designed to help you think about your practice and the kinds of information and examples you might give to demonstrate fulfilment of the outcomes;
c) suggestions of material to which you might find it helpful to refer;
d) fictitious case scenarios (attached as an appendix) which show how demonstrating fulfilment of the outcomes should be rooted in day-to-day professional practice and the importance of standing back from and evaluating your practice.

The prompt questions and fictitious case scenarios offer a mix of guidance. You may find one or the other more useful. The questions vary in style; some help you get started in thinking about your practice and how you keep up-to-date; others ask you to think more critically about your recent and on-going development.

DEMONSTRATING FULFILMENT OF THE OUTCOMES
Using the draft model involves demonstrating how, within your particular scope of practice, you demonstrate fulfilment of the six outcomes. The following elements of the document explain what you need to do.
- What do you have to do?
To demonstrate fulfilment of the outcomes, you need to think critically about your practice, how it has developed and the benefits to the service you are involved in delivering. In terms of process, you need to

- Prepare reflective statements that show how you fulfil the six outcomes
- Provide evidence from your day-to-day professional practice to support your reflective statements
- Prepare a summary statement that highlights your recent professional achievements and your plans for your on-going development.

The diagram below charts the stages that you will find it helpful to go through to do the above.

Diagram 2: Key stages of the process

- Identify incidents or areas on which you intend to focus
- Think about these incidents/practice areas, using the prompt questions to help you
- Make rough outline notes on what you plan to include in your statement(s), using the explanatory material, prompt questions and case scenarios as guidance
- Leave the notes for a while - return to them later to add further detail
- Identify and gather sources of evidence
- Draft reflective statements, strengthen with appropriate references
- Review statements against checklist, Appendix 1 (ask a colleague or friend to give constructive feedback)
- Draft summary statement and review against checklist (Appendix 2)
- Finalise statements

- What material do you already have?
As part of your ongoing development you are likely to have a selection of material, perhaps in the form of a portfolio, that can be used as the starting-point for preparing your statements. You may also have material that you have put together for other purposes that will help you identify your learning and how it
has impacted on your practice; e.g. a personal development plan, appraisal documentation, a business plan (if you are a private practitioner or manager), your job application.

-How many statements do you need?
You are asked to demonstrate how you fulfil each of the six outcomes, not just some of them, through your reflective statements. You can do this in different ways:

• You may be able to produce one statement (e.g. that focuses on one episode or element of your practice, such as your recent management of an individual patient) that relates to all the outcomes (you will need to highlight how different elements of the case study relate to each of the outcomes);
• You may draw on a range of examples from your professional activity and submit six statements (one for each of the six outcomes);
• You may take a mixed approach (e.g. supplying some statements that relate to two or more outcomes and some that relate to individual ones).

However you compile your statement, you need to show your capacity to evaluate your practice:

• If you focus on a specific incident, or incidents, in your practice, you need to draw out broader themes and explain how these represent your practice more generally;
• If you take a broader approach, you need to illustrate what you say with specific examples.

The quality of your statement or statements, in terms of the reflection they show on how you have developed professionally, is more important than the number of statements you write or the length of each.

- Providing corroborative evidence
You will need to supply different forms of corroborative evidence to substantiate your outcome statements. The evidence can take many forms and should be grounded in your day-to-day practice as much as possible. It can include the following:

• Feedback from colleagues, your line manager or others (including patients, carers and students) that testifies to your fulfilment of an outcome (whether directly or indirectly);
• Evidence derived from using audit tools;
• Documentation generated by your involvement in using (or developing) other clinical effectiveness tools, including clinical guidelines, outcome measures or integrated care pathways;
• Materials you have produced for other purposes such as
  o case studies prepared for in-service education sessions or course requirements;
  o patient or other user information leaflets or guidance;
  o practice protocols;
  o documented participation in mentorship or clinical supervision schemes;
  o documented involvement in an inter-professional project;
  o reflective statements prepared for other purposes, such as appraisal sessions, personal development plans, or claims for the academic credit of prior learning;
  o recruitment and retention strategy.

It is important that you respect the confidentiality and anonymity of others, including patients, colleagues and students, in the evidence you provide (some of the above types of documentation may therefore require some adaptation). The statements you produce will be treated as confidential.

You should also consider how your statements can be referenced to strengthen them. Wherever possible, you should refer to policy documents (both national and local), published articles or books, and professional codes, standards and tools that have informed your practice or learning and development in specific areas, using a standard referencing format.
Key questions to consider
When considering examples from your work based activities on which to base demonstration of any or all of the outcomes you need to ask the following questions:

- What did I learn?
- How has this affected my practice?
- What aspects of my practice have changed as a result?
- How may my practice change in the future; will I do anything differently in light of my learning?
- How will I know when this has happened?
- What was the benefit to the client/user/service?
- How does it link with my previous learning?
- Has it changed how I think about my practice?
- Have I identified further learning needs?
- How will I address these?

Underpinning this you need to identify and consider:
- What tools did I use to review/assess/evaluate your practice?
- What sources of evidence did I use?

The prompt questions under each outcome will assist you further in this process of reflection. When thinking about your statement(s) you do not have to answer all the prompt questions directly, although you may find this helpful.

Checklist for evaluating statements
The checklist (appendix 1) should help you take a critical approach to your statements, encouraging you to stand back from what you have written and think about whether it gives the information you are asked, and want, to provide. You may also find it helpful to ask a colleague or friend whose views you respect and trust to look at your statements and give constructive feedback.

Compiling your summary statement
In addition to the reflective statements, you are asked to produce a short summary that draws together how you have fulfilled the outcomes in total and identifies the areas in which you intend to develop in the future. This enables you to focus on your learning achievements and professional development over recent years. Acknowledging you have learning needs is evidence that you are thinking about your ongoing professional development and how you can further enhance your contribution to patient care and service delivery (in whatever capacity you work).

You may find it helpful to follow the basic structure outlined below.

- What are the main ways in which I have developed professionally over the last couple of years
- What have been my main professional achievements?
- How have these achievements benefited my practice?
- What are my current learning needs?
- How do I plan to address these?

The dynamic nature of the model therefore highlights that learning should be career-long and that applying learning to practice – and identifying what you have learned through practice – is cyclical. This process is central to remaining competent.
Sources of support
A list is given below of (each individual profession’s) material that you may find helpful in using the outcomes.

You are also likely to find it helpful to use local sources of support, including arrangements for clinical supervision or mentoring that enable you to discuss your practice and development with colleagues. If such arrangements are not in place, you might want to arrange informal discussion sessions with a peer to help you work through the outcomes, reflect on your practice and formulate your statements. If you work in isolation from other members of your profession, you may find it useful to make use of clinical and occupational networks or other professional networks that may be available to you locally.

If you have any queries about using the model, please contact the following (name and contact details of individual within each profession):

(Name of profession) material you may find helpful
You may find the following (name of profession)publications useful in working through the outcomes:
Outcome 1: Understand, work within, and respond appropriately to the limits of professional practice

Explanatory note
As a professional, you have an obligation to limit your practice to those areas in which you are competent at any one time and to undertake appropriate CPD activity to develop your competence as you move into new areas, and to consolidate and refresh your knowledge and skills in existing ones. Competence is as much about what you decide not to do, as what you decide to do. It therefore hinges on the proper exercise of professional judgement.

This outcome also acknowledges that you have a unique scope of practice within the total, and evolving, terrain of your profession. At any point in your career, some areas and aspects of your profession’s practice will lie outside your competence. You may develop your competence in some of these at a later stage in your career, while you will lose your competence in others. For example, if you move into university teaching, you may not maintain your competence to work as a hands-on clinician without appropriate updating.

You can establish and maintain your competence within your particular scope of practice in many different ways, not simply – or necessarily - by attending courses. Appropriate forms of CPD will depend on the precise nature of your learning needs, the learning resources available to you at any one time and how you prefer to learn (this varies significantly from person to person).

Prompt questions

• How do you define your current scope of practice?

You might find it helpful to do this through describing some or all of the following (the relevance of some of the questions will depend on your professional role and scope of practice):

• Your occupational role (e.g. as a clinician, researcher or educator)
• The sector in which you work (e.g. the NHS, private practice, industry, higher education)
• The environment in which you work (e.g. acute, community, GP practice, school)
• The client group(s) with whom you practise (e.g. children, the elderly, people with learning disabilities, elite sports people)
• The specialty in which you practise (e.g. neurology, women’s health, oncology, musculo-skeletal disorders, education)
• The particular treatment approaches and techniques you use (profession-specific examples)
• The particular types of case with which you tend to deal (profession-specific examples) (e.g. the types of case you tend to refer elsewhere (e.g. within your department or to specialists at a neighbouring centre).
• The diversity of the community that you serve (e.g. in terms of age, gender, race, socio-economic group, disability, sexual orientation, gender identity).

• How has your scope of practice developed or changed recently?

For example, have you

• Become more specialised or changed specialty?
• Returned to practice after a career break?

• Developed a new skill?
• Changed your professional role (e.g. from a clinician to a manager, educator or researcher)?
• Taken on new responsibilities (e.g. by becoming a fieldwork/clinical educator/supervisor, a steward, or your university department’s admissions tutor)?
• Changed your practice setting (e.g. moved from acute to community)?
• Changed the sector in which you work (e.g. from the NHS to Social Services)?

• What have you done to ensure you are safe and effective in your current scope of practice?

For example, have you

• Engaged in activities (e.g. undertaken supervised practice, attended a course or shadowed a colleague) to prepare for your new role or responsibilities?
• Ensured you keep up-to-date with developments relating to your scope of practice?
• Discussed your new role/responsibilities/caseload with your manager or colleagues (e.g. through a mentor, clinical supervision, appraisal scheme)?
• Identified your learning needs and how you can address these?
• Read relevant literature (e.g. research articles, policy documents, legislation, standards, protocols or clinical guidelines) and considered how this relates to you practice?
• Joined a relevant clinical interest, occupational group or network?
• Sought information and advice from the (name of professional body) or another appropriate body?
• Sought relevant information on the diversity of the community you serve and taken steps to ensure that you are able to work towards meeting the needs identified (e.g. employer policies and guidance).
• Taken steps to ensure that you are up-to-date and understand the legislative framework within which you work.

• Can you describe a recent incident in which your professional judgement led you to refer a case or matter elsewhere because you decided it fell outside your current scope of practice?

• What made you decide this?
• What action did you take (e.g. in seeking guidance from others or ensuring an appropriate referral elsewhere)?
• What have you learned from this?

• How do you think your scope of practice might change over the next couple of years?

For example, do you expect to

• Specialise further?
• Change your professional role?
• Take on new responsibilities?
• Change the setting in which you work?
• Practise in an environment that places a greater emphasis on inter-professional working?
• Get more involved in research and development activities?

• How do you plan to prepare for this change?

(Name of profession) material you might find helpful
Outcome 2: Demonstrate effectiveness in practice

Explanatory note
Key to effective practice is the proper exercise of professional judgement and decision-making. While describing the treatment cycle which underpins the care of patients (that includes assessment, decision-making, planning and goal-setting, implementation, evaluation, on-going review and record-keeping), the outcome is relevant to all regardless of occupational role.

The outcome reflects the following attributes and activities:

- Promoting and maintaining a safe and healthy working environment
- Managing time, personal emotions and stress
- Assessing individual need effectively and sensitively, taking into account the impact of religious and cultural beliefs on an individual’s view of their health and the care they anticipate
- Recognising the full range of appropriate action and referring elsewhere when your judgement about the most appropriate course of action lies outside your field of competence
- Planning an appropriate course of action and ensuring its safe, effective and efficient delivery (whether by yourself or someone for whom you have supervisory responsibility)
- Evaluating the effectiveness of a course of action, including its outcomes, and revising goals where necessary
- Recording all aspects of personal activity in accordance with legal, ethical, management and organisational requirements
- Recognising the importance of practising in evidence-based, cost-effective ways
- Recognising the importance of encouraging partnership in decision-making and evaluation, respecting others and engaging in effective team working.

Prompt questions

- Can you show your fulfilment of the outcome through a recent incident or case in which you have been involved?
  - In doing this, it would be helpful if you could describe the individual elements of the process (i.e. your assessment, decision-making, implementation, evaluation etc.)

- How do you keep your effectiveness under review?

  For example, can you explain, or give examples of, how you
  - Reflect on your practice (e.g. by keeping a reflective diary/learning portfolio or discussing emergent issues with your colleagues)?
  - Identify your learning needs and ways of addressing these?
  - Apply your new learning to your practice in appropriate ways?
  - Evaluate how your new learning has benefited your practice?

- How do you ensure that your practice reflects the needs of the ‘whole’ community that you serve?

  For example, can you give examples of how you
  - Take account of inequality and disadvantage?

  - Ensure equitable access to your service?
• How do you seek feedback from peers on your effectiveness?

For example, do you

• Have a mentor?
• Participate in a local scheme for clinical supervision?
• Participate in an annual appraisal scheme?

• What have you learned recently through discussing your practice with peers?

• How have you applied this learning to your practice?

• How do you seek feedback from others (including patients, staff for whom you have responsibility and students) on your effectiveness?

For example, do you

• Participate actively in initiatives to gain patient feedback?
• Engage in ‘360 degree’ appraisal systems?
• Analyse data gained through student evaluation exercises?
• How have you responded to feedback gained in this way?

• How do you ensure you remain up-to-date in relation to

• Your specific area of practice?
• Broader developments within your profession?
• Broader developments affecting your profession (e.g. government initiatives, changes to legislation, changes introduced by your employer or manager, research findings, changes in healthcare delivery, demographic trends)?

• How have you recently used new knowledge or a new skill or approach in your practice?

• How did you gain the new knowledge, skill or approach?
• How did you decide when to apply the new knowledge, skill or approach – and when not to apply it?
• What was the effect of applying your new learning?

• How do you think you might need to develop in the future?
Outcome 3: Practise within the profession’s moral and ethical framework

Explanatory note
Recognising and dealing appropriately with the moral and ethical issues you encounter in your practice is central to being a professional. Your rules of professional conduct provide the ethical framework for your practice and indicate the importance of your

- Ensuring the confidentiality and security of information you acquire in a professional capacity
- Promoting and supporting individuals’ rights and choice in service delivery
- Respecting individuals’ personal beliefs, identity and dignity.
- Recognising the impact of culture and religious beliefs on an individuals’ perception of health/illness/care.
- Recognising the impact of lifestyle and social networks.

Prompt questions

- How do you ensure sound practice in the way you deal with issues of
  - Informed consent?
  - Confidentiality?
  - Individuals’ rights and choice?
  - Respecting individuals’ beliefs, identity and dignity?

For example, how do you

- Follow national/organisational/departmental guidance?
- Contribute to developing guidance at one of the above levels?
- Review your practice in light of particular incidents?
- Create a safe environment in which to explore issues relating to culture/religious beliefs/identity (e.g. stereotyping)

- How have you managed a recent case or incident in which you needed to do one or more of the following:
  - Address a particular issue of confidentiality or consent?
  - Promote an individual’s rights and choice?
  - Respect an individual’s personal beliefs?
  - Understand and empathise with the person’s perspective and priorities?
  - Take account of a particular cultural or socio-economic issue?
  - Address another ethical or moral issue?
  - Address the impact of culture on an individual’s expectations of care?
  - Take account of the impact of your own beliefs/values/attitudes on the therapeutic relationship and or relationship with others?
  - Challenged, or dealt with, an incident where you have witnessed others not valuing the background of those they are seeing (e.g. stereotyping)?

For example,

- On what sources of advice, support or information did you draw?
- What action did you take and why?
• What have you learned from the experience?
• How have you applied your learning to subsequent practice?

• How has the incident affected
  • How you think about your professional practice?
  • How you act in your professional practice?

(Name of profession) material you might find helpful
Outcome 4: Think critically about personal practice and its context

Explanatory note
Standing back from your practice and thinking about it critically is an important aspect of being a professional. Not to do so risks dealing with matters in a routine way and without thinking about the particular characteristics of a situation and their implications for the most appropriate course of action.

Primary ways in which we learn and develop are through

- Reflecting on our experience
- Considering what went particularly well during an episode, as well as what did not go as well as it might and how things might have gone better
- Making links between different experiences
- Making links between theory and practice.

It is also important that you

- Understand how your personal practice relates to the wider picture of your profession
- Evaluate the relevance and applicability of new developments to your practice
- Are aware of the multiple factors affecting your profession's practice (including organisational structures and change, local and national policies, legislation, social and demographic changes, the particular make up of the local community you serve).

Prompt questions

- How do you keep abreast of broad developments in your profession?

  For example, do you

  - Belong to a relevant clinical or occupational group, or a network?
  - Regularly read news items in (Name of profession's news journal)?
  - Regularly read articles in (Name of profession's journal) and other journals relevant to your practice?
  - Read publications affecting the context in which your profession's practice sits (e.g. government documents on the new NHS)?
  - Act in a role for the (Name of profession)?

  • In what audit or research and development activities have you recently been involved (e.g. access to service, referrals, uptake of services by the community you serve)?

  • What have you learned from these activities?
  • How have you applied your learning to your practice (e.g. changed/modified any referral/assessment forms and or therapeutic materials used)?

  • Are there audit or research and development activities in which you expect, or want, to be involved in the future (e.g. compliance with treatment, ethnicity, access to services)?

  • How do you keep abreast of developments affecting your practice?

  For example,
• Changes in {Name of profession's} practice (including those with a multi-professional dimension)
• Changes in the sector in which you work
• Changes in the organisation in which you work
• Demographic changes

• How have you reviewed your practice in light of a recently-introduced policy, protocol or piece of legislation?

For example,
• Discussed and interpreted the impact of policies relating to the diverse needs of the community that you serve.
• Taken steps to find out about the population profile of your local community (e.g. in terms of age range, gender, disability, race, sexual orientation)

• Have you changed your practice as a result?
  • If ‘No’, what made you decide that change was inappropriate?
  • If ‘Yes’, what effect has the change made?

{Name of profession} material you might find helpful
Outcome 5: Deal appropriately with the new and non-routine

Explanatory note
Applying skills and knowledge to a variety of settings and situations so as to respond appropriately to new and changing needs is a core element of professionalism, since professional practice is neither predictable nor routine. Precisely how you deal with the new will depend on how long you have been qualified and your current role.

For example, if you are

- Fairly newly-qualified, your most appropriate response to a new situation may well be to seek advice and guidance from more senior colleagues or your manager
- A specialist clinician, the complexity of your caseload is likely to require you to be genuinely innovative in your practice, drawing on your substantial experience and expertise
- In a leadership role (whether in a clinical, education or research setting), your job is likely to demand you to be innovative and imaginative, requiring you to devise constructive solutions to new issues, challenges and problems, seize opportunities in ways that optimise resources and outcomes, and manage change.

For all – regardless of seniority or role - safe and effective practice is of prime importance. You therefore need to undertake and act upon appropriate assessments of risk, be aware both of the limits of your own competence and your profession’s scope of practice, and have the capacity to transfer and apply knowledge and skills with aptitude and due discretion.

Prompt questions

- Can you describe a recent case or situation in which you encountered something new to you?
  - How was it new?
  - How did you deal with it?
  - From whom did you seek advice?
  - From what information sources did you seek guidance?
  - How did you assess the risk involved?
  - How were you able to apply existing knowledge and skills?
  - How did you decide whether to act or to refer the matter elsewhere?
  - How did you demonstrate your safety and effectiveness in taking the course of action that you did (whether this was to act yourself or refer the matter on)?
  - How did you use any support networks that you have developed?
  - How did you plan to meet any gaps that you identified in your knowledge/experience?
  - Have you identified best practice?
  - What have you learned from the experience?
• How have you applied your learning to your practice (e.g. development of specialist information)?

• How have you demonstrated innovation in a recent aspect of your practice?

  • What have you learned from this?
  • How have you applied your learning to your practice?

{Name of profession} material you might find helpful
**Outcome 6: Communicate and collaborate effectively**

**Explanatory note**
Effective communication and the ability to work well with others are important components of professional practice. The range and nature of communication and collaboration will vary according to your occupational role and setting. However, for all, it is likely that different approaches are required on an on-going basis, including:

- One-to-one contact
- Teamworking
- Acting in teaching and advisory roles
- Receiving complex, and possibly conflicting, information with sensitivity and discretion
- Promoting partnership in decision-making and evaluation
- Negotiation and advocacy
- Preparing written material in different formats
- Liaising with colleagues from other professions and from different organisations.

**Prompt questions**

- In what kinds of teaching or advisory roles do you act?
  
  For example, are you a
  
  - Clinical educator for students on qualifying programmes?
  - Clinical supervisor for qualified colleagues?
  - Mentor for qualified colleagues?

  - What benefits does this activity have for your broader professional role?

- How have you dealt with a potentially difficult situation in either communicating or receiving information (e.g. using an interpreter; giving instructions in a culturally sensitive manner)?
  
  - How did you exercise due sensitivity and discretion?
  - What did you learn from this?
  - How have you applied this learning to other situations?

- What kinds of written material have you recently produced, or been involved in producing (e.g. a patient information leaflet, a project report, a protocol, a course assignment, an article for publication)?
  
  - If you were working on this with others, what was your specific role?
  - What made you decide (either individually or as a member of a team) to produce the material?
  - What factors did you consider in deciding on the appropriate format and content?
  - From what sources did you seek guidance and advice?
  - How have you sought feedback on the finished product?
  - How have you responded to feedback?
  - What other forms of communication have you considered, bearing in mind the diverse nature of the community in which you work?
  - Have you tested the material out and amended it based on the feedback?

- What have you done recently to enhance collaboration with
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- Other members of the profession (e.g. staff for whom you have supervisory responsibility or colleagues working in cognate areas)?
- Members of other professions (e.g. to address an issue of common interest or concern)?
- Support staff?
- Students (e.g. for whom you have responsibility as a university educator or as a clinical educator while they are on placement)?
- Patients (e.g. to address a particular issue around health promotion or to tackle problems with unkept appointments)?

For example,

- Have you used them as a source of support and information?

When collaborating with others how have you

- Assessed the appropriateness of your communication, in particular any material used?
- Made use of local networks?
- Made use of Interpreters and or support workers?
- Provided a safe environment to explore sensitive issues?

(Name of profession) material you might find helpful
## Appendix 1.

**Checklist for evaluating statements**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes/No/Comments</th>
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</thead>
<tbody>
<tr>
<td>Do your statements and supporting evidence cover all six outcomes?</td>
<td></td>
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<tr>
<td>Have you used your material to best effect? (For example, does material that you have used in relation to one outcome relate as much to, or more to, another outcome? Could you restructure or re-order your material to maximise its relevance?)</td>
<td></td>
</tr>
<tr>
<td>Have you broadly responded to the prompt questions? (You do not need to answer them all individually; they are there to guide the kind of material you should be providing.)</td>
<td></td>
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<tr>
<td>How well have you evaluated your practice and learning? (It is not enough simply to describe what you have done or your professional role.)</td>
<td></td>
</tr>
<tr>
<td>Have you included appropriate references to sources and tools that relate to your practice to give weight to your statements and demonstrate your engagement with evidence-based practice, for example:</td>
<td></td>
</tr>
<tr>
<td>• relevant research and scholarly articles,</td>
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<tr>
<td>• clinical guidelines,</td>
<td></td>
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<tr>
<td>• National Service Frameworks [NSFs],</td>
<td></td>
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<tr>
<td>• outcome measures,</td>
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<tr>
<td>• standards and protocols,</td>
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<tr>
<td>• legislation</td>
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<tr>
<td>• benchmark standards</td>
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<tr>
<td>Have you identified your learning achievements and current and future learning needs (including how you plan to address these)?</td>
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<tr>
<td>If you have focused on specific incidents, have you drawn out broader issues and principles and demonstrated how you have subsequently applied these to your practice?</td>
<td></td>
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<tr>
<td>If you have given broad, general accounts of your practice, have you substantiated these by reflecting on specific areas of, or incidents in, your practice?</td>
<td></td>
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<tr>
<td>Does your summary statement provide a concise, but full, account of your learning achievements and plans for your further professional development?</td>
<td></td>
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</tbody>
</table>
Annex B

Summary of discussions regarding profession-specific analysis of the pilot exercise and Generic outcomes model

Annex B comprises two documents. The preface provides a summary of the proposed profession-specific and collective refinements and developments. The second document is the generic outcomes model which incorporates the work on cultural competence and diversity. Together, they form a basis for future work.
<table>
<thead>
<tr>
<th>Profession</th>
<th>Key points from discussion</th>
<th>Profession-specific</th>
<th>Future project work</th>
</tr>
</thead>
</table>
| BAAT       | • References to image-making and specific art therapy practice to be incorporated into the model (done)  
• The number of outcomes to be reviewed following the work of the steering group on diversity and feedback from ARC on this  
• Further project work should explore how the model could be presented i.e. more user friendly, how it relates to current CPD schemes and the relationship between CPD and competence  
• Further consideration needs to be given to how part-time, unemployed, private practitioners, single handed workers and sessional workers are supported in CPD  
• Consideration to be given on how the networks established by the professions through this project can be maintained, to facilitate further sharing and the impetus of the work | • Review whether outcome 7 should be incorporated into the six outcomes, taking account of pilot participant feedback (this expressed a preference to the outcome being integrated into the other six)  
• Presentation of the model and links with current CPD schemes and structures | • Facilitate further profession-specific refinements alongside developing the presentation of the model  
• Map the links to other structures  
• Continue to explore the outcomes–based approach as a means of demonstrating competence  
• Develop training packages |
| APMT       | • How to support members develop skills in reflection and critical evaluation and demonstrate clinical music skills within their portfolios  
• Simplification of the presentation of the model and more explicit links to CPD schemes, local appraisal schemes and supporting structures e.g. APMT competencies  
• How to support individuals engaging with the process and accessing relevant information and funding | • Incorporate elements around diversity.  
• More explicit links to current CPD schemes and other relevant schemes/structures | • Facilitate further development of the profession-specific model  
• Map the links to other structures  
• Develop training packages |
| SoR        | • The society wishes to review the model in depth and reflect the feedback | • Re-formulate the outcomes, | • Facilitate further |
received from pilot participants, in particular making the technical and practical aspects of their work more explicit
• Following development the draft model would need to be piloted in order to establish whether the approach was suitable for radiographers
• Any future bid should incorporate work looking at monitoring and verification systems and presentation and development of the model
• Identification of learning needs and materials to support members in developing skills in reflection

explanatory note and prompt questions to reflect more specifically the work of radiographers
• Incorporate elements relating to diversity
• Consider the links to the current SoR CPD scheme and the development of training materials

development of the profession-specific model
• Opportunity to pilot the new draft model
• Explore monitoring and verification systems
• Explore how the presentation of the model can be simplified and presented in electronic format
• Continue to explore the underpinning concepts of the approach and its relevance to the profession

<table>
<thead>
<tr>
<th>Profession</th>
<th>Key points from discussion</th>
<th>Profession-specific</th>
<th>Future project work</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPA</td>
<td>The connections with current structures e.g. portfolio development, need to be strengthened</td>
<td>Incorporate elements around diversity</td>
<td>Facilitate further profession-specific refinements alongside developing the presentation of the model</td>
</tr>
<tr>
<td></td>
<td>Further work on the presentation of the model would be supported</td>
<td>Develop the profession-specific model following further work on its presentation</td>
<td>Explore monitoring and verification systems</td>
</tr>
<tr>
<td></td>
<td>Consideration about how to support members engaging with CPD</td>
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<tr>
<th>Profession</th>
<th>Key points from discussion</th>
<th>Profession-specific</th>
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</tr>
</thead>
<tbody>
<tr>
<td>SOCP</td>
<td>How to support members develop skills in reflection and developing their portfolios</td>
<td>Develop the profession-specific model following further work on its presentation</td>
<td>Explore monitoring and verification systems and the impact; e.g. costs of implementing a system and meeting training needs</td>
</tr>
<tr>
<td></td>
<td>Particular consideration needs to be given to how to engage private practitioners</td>
<td>Consider the needs of private practitioners</td>
<td>Facilitate further profession-specific refinements alongside</td>
</tr>
<tr>
<td></td>
<td>Any further work should consider monitoring and verification systems, training needs and the cost of implementing a system</td>
<td>Incorporate elements relating to diversity</td>
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<tr>
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</table>
| IBMS       | • There is strong support for an outcomes-based approach to CPD that incorporates reflective practice  
• Closer links need to be made to standard operating procedures and other structures e.g. quality assurance that biomedical scientists work within  
• The outcomes need to be more profession-specific to reflect their working environment and core skills  
• The institute is looking at ways of engaging its members by supporting them in developing skills in reflection and recording these  
• Any future project work should explore monitoring and verification systems | • Incorporate elements around diversity.  
• Re-formulate outcomes to reflect the needs of biomedical scientists, including being specific about the links to other structures and systems. | • Facilitate further development of the profession-specific model.  
• Opportunity to pilot the new draft model ensuring that all disciplines within biomedical scientists are covered; a longer time frame and closer contact with the pilot sites should be considered  
• Explore monitoring and verification systems |

| BDA        | • Working collaboratively as a group of AHPs has been a positive experience and further work on this basis would be supported, both on this project and others  
• Consideration of the presentation of the model alongside amendments to make the links more explicit to current structures and schemes  
• Consideration will be given to how the draft model can be taken forward within the profession while supporting the development of a bid for further funding  
• Any bid for further funding needs to consider the training needs of staff and the implications of rolling the model out | • Incorporate elements around diversity.  
• Consider how the elements which relate to current structures, both within the profession and outside of it, can be made more explicit | • Facilitate further profession-specific refinements alongside developing the presentation of the model  
• Map the links to other structures  
• Explore training implications and how to support introducing the model |

Developing the presentation of the model:
• Explore the needs of private practitioners through further piloting.
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<thead>
<tr>
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<th>Profession-specific</th>
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</thead>
</table>
| BOS        | The links to BOS competencies relating to technical expertise should be strengthened within the model  
A review of the prompt questions and the perceived overlap between questions could form part of considering the presentation of the model  
Training on reflective practice and writing is required and could be run on a multi-professional basis | Incorporate elements around diversity.  
Identify the relevant links to the BOS competencies within the draft model. | Facilitate further profession-specific refinements alongside developing the presentation of the model  
Training on reflective practice and writing |
| BAPO       | The needs of contractors and their role in supporting CPD needs to be explored  
Monitoring and verification mechanisms to be explored.  
Consideration to be given to developing a small number of profession-specific scenarios  
Time and support of all employees for CPD  
Further exploration of how the professional body can support members engage with CPD | Incorporate elements around diversity. | Facilitate further profession-specific refinements alongside developing the presentation of the model  
Systems for monitoring and verification  
Explore how staff who are not employed directly by the NHS can be support in engaging with CPD |
| CSP        | Ensure full integration within existing and developing schemes, tools and frameworks as well as exploration of monitoring and verification systems  
Exploration of how the links with existing material and schemes within CSP be more explicit  
Continued development of the presentation of the model. | Incorporate elements around diversity.  
Consideration of how the links with existing structures can be strengthened. | Facilitate further profession-specific refinements alongside developing the presentation of the model |
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</tr>
</thead>
<tbody>
<tr>
<td>SALT</td>
<td>How can professional bodies individually and on a group basis support members in engaging with the models</td>
<td>Incorporate elements around diversity.</td>
<td>Facilitate further profession-specific refinements alongside developing the presentation of the model.</td>
</tr>
<tr>
<td></td>
<td>How to move forward and support the cultural shift that needs to take place to see the value of reflecting on practice and thinking critically about it</td>
<td>Consideration of the links with the draft model and other structures that are in place e.g. supervision</td>
<td>Map the links to other structures</td>
</tr>
<tr>
<td></td>
<td>Ongoing discussion and contact as a group of AHPs will facilitate the development of the group’s thinking relating to competence and CPD as well as provide a forum for sharing practical ideas</td>
<td></td>
<td>Develop a range of training packages in a variety of forms.</td>
</tr>
<tr>
<td></td>
<td>Ongoing development of the model and links with the wider structures that staff work within</td>
<td></td>
<td>Continue to explore and develop the concepts relating to competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Explore monitoring and verification systems</td>
</tr>
<tr>
<td>BADTh</td>
<td>Strong support for simplifying the presentation of the model.</td>
<td>Incorporate elements around diversity.</td>
<td>Facilitate further profession-specific refinements alongside developing the presentation of the model.</td>
</tr>
<tr>
<td>Profession</td>
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</tbody>
</table>
| COT        | • Continued development of tools and systems to support members engaging with CPD  
• Development of monitoring and verification systems that includes exploring what is already in place  
• Consideration of how the draft model can be taken forward within the profession | • Incorporate elements around diversity.  
• Strengthen links with existing structures | • Continue to explore the underpinning concepts and in particular how far the model can demonstrate competence  
• Explore monitoring and verification systems  
• How to support and empower members of the professions in engaging with CPD  
• Facilitate further profession-specific refinements alongside developing the presentation of the model |
| CS         | • Strong support for an outcomes-based approach to CPD that incorporates reflective practice  
• Exploration of monitoring and verification systems to be considered in future work  
• Further consideration given to how the model relates to existing and new systems and structures | • Further consideration about how the outcomes can be customised for clinical scientists | • Facilitate the development of a draft model utilising the findings from the current project  
• Pilot the model across the range of disciplines in clinical scientists  
• Map against existing and new structures/systems |

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Appendix I

Glossary of terms used within the project

The glossary explains the intended meaning of terms used within the project. Some of the terms (e.g. ‘prompt question’) are specific to the project, and are italicised for ease of reference. Others (e.g. ‘appraisal’) clearly have a much broader usage. The definitions used within the project complement those provided in other contexts.

Appraisal
The process (usually conducted on an annual, cyclical basis), enacted through constructive discussion, that allows an employee’s performance to be evaluated (usually by their line manager) against agreed criteria or standards, the outcome of which should be the identification of objectives for on-going learning that accord with the individual’s job role and development needs and the broader strategic direction of the department/organisation.

Assessment/treatment cycle
The cyclical process, undertaken in collaboration with the patient/client and carer and with due sensitivity to their needs and wishes, through which a practitioner gathers and analyses information, undertakes an assessment, plans and implements a treatment plan, evaluates the outcomes of this and transfers care or implements a discharge process, as appropriate.

Case scenarios
The package of fictitious outcome statements prepared in different styles and formats to illustrate how users of the draft outcomes models might demonstrate their fulfilment of one or more of the outcomes relating to demonstrating competence through evidence of CPD.

Clinical audit
A cyclical process that centres around identifying a topic, setting standards, comparing practice with those standards, implementing changes and monitoring the effect of those changes with the aim of improving patient/client care and service delivery.

Clinical effectiveness
The extent to which specific clinical interventions, when used for a particular user or user group, do what they are intended to do to maintain and improve health and secure the greatest health gain from the available resources.

Clinical guidelines
Statements developed through systematic processes to assist practitioners, users and carers in making decisions about appropriate forms of health and social care in particular clinical areas, taking account of individual circumstance and need.

Clinical supervision
A structured, formalised approach (for which time is set aside) for discussing professional practice with a colleague or peer that encourages reflection on, and evaluation of, clinical decision-making and outcomes.

Code of conduct
A statement published by a professional or statutory regulatory body that sets out the professional and ethical behaviour required of all members of the profession(s) concerned and that may have disciplinary procedures attached to it.

Common framework
The document formulated during the project’s early developmental phase through consensus-building that sets out the principles the participating professions believe must underpin the profession-specific
models for demonstrating competence through CPD and that was reviewed and revised following analysis of the pilot exercise and subsequent project activity.

**Competence**
The complex synthesis of knowledge, skills, values, behaviours and attributes that enable individual professionals to work safely, effectively and legally within their particular scope of practice that has at its core concepts of professionalism, autonomy, self-regulation, awareness of the limits of personal practice and the practice of the profession to which individuals belong, and within which structured, career-long learning and development to meet identified learning needs forms an integral part.

**Continuing professional development (CPD)**
A wide range of learning activities through which professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice.

**Critical thinking**
An approach that should be integral to individuals’ professional practice in which they consciously consider their decision-making and problem-solving and evaluate aspects of their behaviour and practice that might otherwise be tacit, assumed or unquestioned. Such a process should deepen individuals’ understanding of their professional practice and role and bring about new learning through encouraging a questioning approach and the synthesis of new and past perceptions and experience, drawing on the best available evidence [see also Reflective practice and Evidence-based health & social care].

**Evidence**
Material to be submitted in support of individuals’ outcome statements to corroborate the reflective writing contained within these that may take a number of forms and be in a range of media, including resources rooted strongly in everyday professional practice (adapted to preserve users/colleagues/students’ confidentiality and anonymity), demonstrations that individuals have stood back from and evaluated their practice, and external verification of practice from colleagues and others.

**Evidence-based health and social care**
A commitment to use the best available evidence to inform decision-making about individuals’ care - and the organisation of that care - that involves integrating practitioners’ professional judgement and experience with evidence gained through systematic research and that respects users’ preferences and beliefs.

**Health Professions Council (HPC)**
The statutory regulatory body for the allied health professions [AHPs], formed in April 2002 (as the successor to the Council for Professions Supplementary to Medicine [CPSM]), that is expected to introduce a re-registration scheme by 2006, thereby making AHPs’ retention of statutory registration conditional upon certain (as yet, unspecified, requirements).

**Informed consent**
The process that underpins partnership with patients/clients through which care is taken to ensure that individual users (or their carers or others designated to act on their behalf in cases where they are not able to give consent) can decide whether to agree to a particular intervention based on their receiving sufficient information, in a way they can understand, and so that they feel comfortable with the planned course of action.

**National service frameworks [NSFs]**
Government-initiated documents that describe the clinical standards, service models and performance indicators to enhance the quality of user care and service delivery, while ensuring greater national consistency, within particular areas of care.
Outcomes
The central elements of the draft profession-specific models for demonstrating competence through CPD that seek to encapsulate the broad competence of members of the profession concerned and that promote a focus on learning achievements, the application of learning to practice and the evaluation of the impact of learning on practice.

Outcome statement
The accounts produced by participants to articulate fulfilment of the outcomes contained within the draft profession-specific models that are reflective in style, focus on the what learning has been achieved and how this has been applied to practice and that are supported by appropriate references and corroborative evidence. (The statements can address the outcomes singularly, in clusters, or in their entirety; see also Summary statement.)

Outcomes-based approach
An approach to providing evidence of continuing professional development [CPD] that can attest to on-going competence that focuses on individuals’ learning achievements, their application of learning to practice and the benefits of this, rather than simply input (e.g. the amount of time devoted to learning activities or the amount of credit accrued through undertaking formal learning programmes).

Patient partnership
An approach to health and social care within which the goals, expectations, needs and abilities of users and carers form the focus of all interventions and within which decision-making, goal-setting and evaluation are undertaken in genuine collaboration, with full consideration given to issues of communication, confidentiality and informed consent.

Peer review
A structured, constructive assessment of professional performance undertaken by a colleague who has similar experience and knowledge with the aim of identifying learning needs and ways of enhancing the individual’s practice and contribution to service delivery.

Personal development plan
A tool designed to help individuals, in collaboration with and with appropriate support from managers, to take a structured approach to identifying and addressing their on-going learning and development needs in ways that relate directly to their professional role and priorities for service delivery and that is designed (e.g. within the NHS) to be used to strengthen activities such as annual appraisal.

Portfolio
A resource (that might be in hard copy or electronic format) that helps professionals to record, evaluate and reflect on their learning and that provides a tool for identifying on-going learning needs and planning activity to meet these and that can be used to support a range of purposes (including preparing for annual appraisal, applying for a new job and seeking academic credit for work-based learning).

Professionalism
The values that underpin AHPs’ approach to their professional practice that can be summarised as

- Being motivated to deliver a service to others
- Adhering to a moral and ethical code of practice
- Striving for excellence
- Maintaining an awareness of limitations and scope of practice
- Being committed to empowering individuals and teams.
Profession-specific models
The sets of draft materials each designed to encapsulate the broad professional competence of the profession concerned and to provide a tool to assist individuals in structuring and evaluating their on-going learning and development and to demonstrate their on-going competence.

Prompt questions
The underpinning elements within the draft outcomes models designed to help individuals relate the various outcomes to their professional practice and to help them think about how they can best demonstrate their fulfilment of the outcomes within their particular scope of practice.

Reflective practice
The structured process of reviewing an episode of practice to describe, analyse, evaluate and inform professional learning in such a way that new learning is identified, modifies previous perceptions, assumptions and understanding, and informs subsequent practice.

Re-registration
The process that the Health Professions Council [HPC] is due to begin introducing by 2006 that will make individuals’ retention of state registration conditional upon their compliance with certain, as yet, unspecified requirements (and over which the AHPs are seeking to gain an appropriate influence through the current project).

Scope of practice
The particular, and unique, parameters of individuals’ professional practice at any one point that sit within the broad terrain of the practice of the profession to which they belong, that

- Is shaped by career stage, practice setting and occupational role
- Defines the limits of professional competence
- Evolves and shifts as individuals develop in line with service demands and career progression.

Standards of practice
Documents produced by professional bodies for their members (and for reference by others) that complement codes of conduct by describing in clear, measurable ways the key attributes, behaviours and values that should be articulated in individuals’ professional activity and delivery of services.

Summary statement
The overarching account that participants are asked to complete that explains how they have developed within their professional practice over recent years, what they have learned, how they have applied their learning to their practice and with what outcomes, and how they intend to develop in the near future in line with service needs and career plans.

User involvement
An approach to health and social care delivery that recognises the central importance of the concepts encapsulated in the notion of patient partnership, as well as the need to gain user and carer views through structured approaches on broader issues relating to how services are organised and delivered and the part played by users and carers in the care they receive (including through self-help).
Appendix II

Project Steering Group:
Terms of reference and membership

Terms of reference
The Steering Group is a time-limited group convened to oversee the AHP project on demonstrating competence through CPD.

The group’s role is to

1. Guide and monitor the project, through its receipt of progress reports, in accordance with the purpose, objectives, intended outcomes and timescales stated in the project plan;
2. Maintain an awareness of developments within and outside the AHPs and their regulatory context and appraise the impact on these on the project’s progress and direction through appropriate exploratory activity;
3. Oversee the co-ordination and appropriate integration of all project elements, including arrangements for wide-ranging consultation and piloting, to ensure the creation of a common framework, or set of principles, and profession-specific models and the thorough evaluation and refinement of these;
4. Ensure that an appropriate balance of involvement of each of the participating professions is achieved and maintained throughout the project;
5. Advise on the substance and quality of draft and final versions of the project products and project reports;
6. Advise on publicising and disseminating the project outcomes and products, giving active consideration to promoting these, particularly with a view to the project’s work securing an appropriate influence over future arrangements for re-registration;
7. Advise on the need for, and direction of, future work arising from the project’s outcomes.

Membership, accountability and reporting links
The Steering Group comprises the following members:

- One representative of each of the participating professional bodies;
- A representative of the education and training committee of the Health Professions Council;
- A representative of the Allied Health Professions Forum;
- A representative of the Department of Health;
- One representative from the Scottish Executive, National Assembly for Wales and the Northern Ireland Assembly;
- A representative of the medical profession sought through the General Medical Council;
- A representative of the nursing profession sought through the UKCC/Nursing & Midwifery Council;
- A representative of the social care professions sought through the General Council for Social Care;
- A representative of a patient representative organisation.

The group will need to monitor the desirability of making additional co-options, taking account of its remit and size.

Frequency and scheduling of meetings
The Steering Group will meet as required for the duration of the project.

Style and format of meetings
The group will need to give careful consideration to the style and format of its meetings to ensure its effective and efficient management of business.

Links with the project operational group
An operational issues group comprising the project managers, staff and representatives of each of the participating professional bodies, will meet as and when required for the duration of the project to expedite practical issues relating to the project’s progress. It will be important that this group, and the
project steering group, retain strong links and lines of communication.

February 2003
Appendix III

Project Operations Group:
Terms of reference and membership

1. The group convenes to

   i. Create an easily accessible source of advice and information from the participating professions for the duration of the project;

   ii. Facilitate the supply and exchange of information and documentation to assist in the initial induction of project staff and in their securing and maintaining strong links with each of the participating professions for the duration of the project (particularly in the context of consultation, developmental work, consensus-building and pilot activity);

   iii. Discuss and advise on arrangements for the on-going publicity of the project, particularly through co-ordinating timescales and the production of shared copy for use in each profession's journal and/or bulletin at crucial project stages;

   iv. Advise on addressing and resolving other operational and practical issues as they arise through the course of the project, referring any matters, as appropriate, to the project steering group.

Membership

2. The group comprises representatives of each of the participating professions within the project. Representatives are likely to be officers or members who carry particular responsibility for activities and policy development relating to CPD and/or professional competence.

3. It is at the discretion of each participating profession who, and how many representatives, it sends to each meeting (although this is unlikely to need to exceed one or two representatives at any one meeting).

4. Alternates are welcome to attend meetings to ensure professions’ full involvement in discussions on operational issues at each stage of the project and to maintain awareness of requests to supply and exchange information to expedite the project’s progress.

Meeting arrangements

5. The group will meet as and when required during the project. It will schedule its meetings at times that optimise its usefulness in making practical arrangements for the efficient and effective completion of work by project staff (in particular, to assist in the fulfilment of responsibilities relating to consultation and pilot site development and support).

6. The group will rotate the venue of its meetings, using the accommodation of participating professional bodies by invitation and according to availability.

Minutes and their circulation

7. Notes of meetings will be taken by the project administrator and circulated by e-mail as soon as practicable thereafter, with expectations of required action by group members highlighted (for example, the exchange and supply of information and accompanying deadlines).
Reporting links

8. The group will submit regular, brief reports to the project steering group to advise on operational developments and highlight any issues pertinent to the project’s progress and successful completion.

November 2001
Executive summary

This report describes the results of the first project task of mapping the material provided by the professions and the initial consultation exercise. The methods used were designed to enable the professions to share ideas and knowledge while giving an opportunity to explore the concepts of the project.

The key points are as follows:

- The professions involved have a strong base from which to work and develop ideas relating to a common framework for an outcomes based approach and subsequent profession specific models.
- Within this it is anticipated that the concepts of an outcomes based approach, professional competence, CPD and links between the two will be explored further.
- The development of a practical framework with supporting tools is seen as crucial for members.
- The multi-disciplinary nature of the project and its accordance with the governments agenda are seen as key strengths.
- The key drivers for involvement in the project are seen as the opportunity to influence the thinking of the HPC and to share ideas and inform the development of CPD approaches and tools within the individual professions.

Abbreviations used:

AHP: Allied Health Profession
CPD: Continuing Professional Development
DoH: Department of Health
HPC: Health Professions Council
LLL: Lifelong Learning
PDP: Personal Development Plan
Introduction

1. This report outlines the results of the initial project tasks of mapping the material provided by the professions and the initial consultation exercise. It comprises the following sections:

- an explanation of the methodology
- main findings of mapping exercise
- summary of the initial consultation
- areas of commonality
- strengths on which project can build
- areas for development (questions for further exploration/resolution)
- summary
- appendices

2. The key purpose of the initial stage of the project was to raise awareness and gather information to inform the consultation process and underpin the next development stage.

Methodology

Consultation

3. This was achieved through semi-structured interviews based on core questions, adapted as appropriate and circulated prior to the interview with a briefing paper in order to utilise time effectively. This also provided a framework for collating the information gathered. Twenty-one people were interviewed of which the majority were face to face and lasted on average 90 minutes, with a few by telephone and one by email. Information was recorded on an expanded question sheet, which facilitated collection and collation of material.

4. The commitment from all concerned was very high and was reflected in their willingness to find time to prepare for and be interviewed.

5. The people interviewed fell into one of four groups:
   - Professional representatives
   - Shadow Health Professions Council
   - Department of Health
   - User representative

Mapping of information

6. The methods used in mapping the material provided by the professions and the initial consultations were designed to enable the participating professions to pool their expertise and knowledge.

7. The project manager requested material from the professions involved in December 2001, prior to the project officer and administrator coming into post. Each profession was asked to provide as wide a range of material as possible but which related to the key areas of the project; i.e. competence, Continuing Professional Development (CPD)/Life Long Learning (LLL), portfolios, professional information & relevant briefing/guidance papers. This request was repeated in January 2002 with a deadline of 14th February 2002 for the final receipt of materials.

6. A wide range of material was provided by the various professions reflecting the diversity and needs of their members. Using qualitative research based methods the material was initially screened and then organised and evaluated under the following headings:

- Codes of Conduct/Practice
- Standards of Practice
- References to Competence/CPD in Codes of Conduct
- References to Competence/CPD in Standards of Practice
9. The material was evaluated by tabulating the information under headings, cross-referencing where appropriate, comparing and contrasting. Doing this meant it was possible to:
   - Identify links between codes of conduct/standards
   - Identify central themes/key areas
   - Identify areas of commonality
   - Identify areas for development

10. When deciding on headings some general interpretation had to be made where professions had organised information under different headings or described them differently. For example, competence was described under a range of headings including “Professional Competence”, “Scope of Practice”, “Professional Competence and Standards”.

Main findings of mapping exercise
Codes of Conduct/standards of practice

11. Of the thirteen Allied Health Professions (AHPs) involved at this point in the project, ten provided codes of conduct, which are seen as the framework for professional and personal conduct. They set out the principles and values (ethical framework) that apply to members and reflect professional’s duty of care.

12. Eleven professional bodies provided standards of practice, the core purpose of which is to provide a foundation for good practice. For two of the professions, the standards are seen as the minimum level of practice; for others they are seen as promoting best practice and in some instances can be adapted to suit local circumstance. They vary in depth, breadth and presentation, ranging from three pages to several documents in a binder. Five of the professional bodies see them as applicable to all members; i.e. students and support workers, as well as qualified members.

13. It is clear from the references between the codes of conduct and standards of practice that, together, they are seen as providing the professional framework within which members should work. Three of the standards of practice form companion documents with the codes of conduct. When taken together as a professional framework, it is possible to identify the following central themes:

   - Duty of care
   - Client autonomy, dignity & rights, confidentiality
   - Client focused/needs led services
   - Personal and professional integrity
   - Maintaining competence, working within scope of practice, identifying learning needs and planning to meet these usually through CPD
   - Development of evidence based practice
   - Collaborative practice
   - Communication
   - Documentation/records of treatment

14. Within the central themes identified eleven of the professions make reference to competence and/or CPD. This ranges from one sentence to whole sections and described variously as “Professional Competence” and “Standards”, “Professional Development”, “Scope of Practice” and “CPD/LLL”. Within this it is possible to identify the following commonalities:

   It is seen as the individual’s responsibility to
15. Many of the codes of conduct and standards of practice have been revised in recent years and in these instances it is clear that the professional bodies have reflected the changing context in which members work. This is reflected in the references to competence, CPD, LLL, quality and audit, evidence based practice and inter-professional working.

16. Within the standards reference is made to quality and audit with four of the professions providing tools to facilitate audit. In other instances the standards are supplemented by additional material (e.g. audit pack or briefing paper on clinical governance). The professions are keen to support members using audit on a regular basis as part of monitoring their contribution to service delivery and patient care.

17. Although the codes of conduct vary in depth, breadth and size, ranging from two to 34 pages, certain areas are common. These are listed below:

- Client autonomy, dignity and rights, confidentiality, cruelty and abuse
- Referrals
- Relationships with clients
- Personal integrity
- Professional integrity
- Advertising
- Clinical competence
- Collaborative practice
- CPD

18. In some instances different headings or language are used; for example the responsibility of the individual to practise within the limits of their competence was described under scope of practice for one profession and professional competence for another.

**Approaches to CPD**

19. Twelve of the participating professions provided material on their approach to CPD and this has been mapped out by looking at the main components, definitions and the tools available. The material provided ranged from two pages to a series of information/guidance papers plus tools to assist the individual member. From the range of definitions provided it is possible to distil the common view that:

**CPD should be seen as a systematic, ongoing, structured process of maintaining professional development by**

- Promoting reflective activity, both individually and within teams
- Promoting identification of a wide variety of learning opportunities
• Actively assessing learning needs, identifying learning outcomes, planning to meet these, evaluating activity and re-starting the cycle

*That the key outcomes of CPD activity should be*

• The application of learning to practice
• Continued competence to practise
• Meeting the needs of the patient/client and the service (whether directly or indirectly).

20. Within the approaches, a wide range of CPD activities are promoted.

21. The approaches taken can be divided into the following categories:

• **Hours-based**: six of the professions recommend a number of hours to be spent on CPD per year; five of the professions see these hours as the minimum; three have gone one step further and linked the hours to particular activities.
• **Points-based**: one profession refers to points (1 point = 1 hour) and these are linked to recognised activities and periods of time.
• **Credit-based**: one profession has recognised educational and professional activities and credits are awarded for participation in these, with a recommendation about how much credit should be accrued each year.
• **Individual need** - the remainder look to the individual to identify what they need to do based on an analysis of their learning needs and the development of a plan to meet these, with the time needed to achieve the plan is then negotiated with the employer (where appropriate).

22. A number of the approaches taken are either currently being reviewed or about to be and information from these exercises may well be relevant to share within the project.

**CPD Tools**

23. A broad range of CPD tools has been developed which vary in depth, breadth and presentation. The tools are a mix of paper and CD ROMs, comprising mainly portfolios, CPD logs/statements, courses accredited by the professional body and systems for managing CPD. They include an example of a locally developed staff development tool for the paramedic service in Essex. This reflects the local nature of employment for the paramedics and, as such, is valuable to consider when looking at the contexts in which staff work. As a new professional body, the British Paramedic Association will be looking at how they can progress policies at a national level.

**Competencies**

24. In trying to provide a variety of tools to assist members with their CPD some of the professions have started to look at developing frameworks which help the individual describe their practice. The British Association of Art Therapists CPD working group is looking to agree a menu of “professional competences” as the next step in supporting art therapists demonstrate their competence. This is currently in draft form.

25. The Royal College of Speech and Language Therapists is in the process of piloting what has been an extensive piece of work to develop a model of speech and language therapy that captures some of the dynamic and complex nature of Professional Practice. This offers a competencies framework which members can use to explain and reflect on their practice and thereby facilitate their CPD. The model takes an holistic approach presenting competencies in a series of layers: an outer layer of task competencies, a middle layer of process competencies and the inner core of judgement and decision making competencies. These are seen as the WHAT (tasks), HOW (processes) and WHY (judgement and decision making) of practice. The framework is seen as having broad application within the profession (Williamson, 2001).
Supporting information

26. A broad range of underpinning/supporting information was provided, with the largest groups of material relating to guidance documents (for example, on audit, research, mentoring, supervision) and back up information on CPD, educational needs/issues and return to practice after a career break.

Summary of initial consultation

27. The interviews provided the opportunity to discuss issues arising from the material provided by the professional bodies, as well as to gain initial views for other project stakeholders. While there was some diversity across those interviewed there were also similarities. Common issues to arise were as follows:

- How will the identified outcomes be evidenced and verified?
- How do we engage members in demonstrating their competence?
- How do we ensure that it links to other systems? (e.g. appraisal, supervision)
- Will it be inclusive of roles and context?
- Will it be practical, understandable?
- Will it help practitioners develop reflective practice skills?
- Will it incorporate other models?
- Will it address the issues of funding & the commitment of employers?
- Recognition that CPD activity alone is not enough and that professional competence is more than this
- Delivery of quality, safe, effective services to clients
- Complexity of defining professional competence and therefore of identifying links between this and CPD and then outcomes
- Outcomes are seen as broadly transferable
- Definitions of CPD were varied but had similar components.

28. During the consultation the individual professions expressed a willingness and enthusiasm to be involved in the project, seeing it as an opportunity to strengthen relationships and influence the thinking of the HPC. Everyone is keen to share information and look at ways of engaging members. It is also hoped that the project will inform the development of individual frameworks and tools, in particular reflective practice and portfolios.

29. The responses to the questions on definitions suggest that the concept of an outcomes based approach has not yet been fully grasped or explored by all of the professions. There is also a need to develop a common understanding and language related to professional competence, CPD and the links between the two. Defining professional competence proved to be one of the more challenging questions, reflecting the difficulty we all have in describing what it is that we do. It is anticipated that providing an opportunity to discuss these ideas further will inform the next stage of the project and clarify how profession-specific models can be developed.

30. While the six outcomes identified by CSP are seen as broadly transferable it is anticipated that the significance of the model as a CSP tool should now begin to lessen. While the AHPs are committed to this project it is anticipated that there are a number who may explore other approaches at the same time.

31. The main driver for the HPC is to safeguard the health and well being of the public and it recognises that a link needs to be made between continuing competence and re-registration. While acknowledging that this is a complex process the HPC is looking for some practical suggestions and a broad framework that covers all of the professions while recognising their individuality. They are concerned with what are the minimum requirements to remain on the register and will be looking at a range of things that might inform their eventual decision about how to proceed on this issue.
32. In looking at an outcomes-based approach the HPC would like to see work done on what evidence will look like, how it will be assessed and verified, and how an outcomes based approach relates to inputs model (e.g. hours). It feels that a strength of the project is that it is multi-professional and in line with government agenda.

33. The DoH feels that this model is highly transferable and sees its main strength in being multi-professional and having the potential to offer suggestions to the HPC. Professional competence is seen as having a number of dimensions, including specific skills and knowledge, team working skills, communication and interpersonal skills, attitudes and behaviours. It is anticipated that the project will explore the outcomes based approach further, its links to CPD and the role of work based learning especially within the multi-disciplinary team.

34. From a user perspective CPD is seen as essential; in particular keeping up to date with research findings/evidence and basing practice on this. Therapists also need to look at the evidence available on the techniques they are using, to ensure that they are still valid. Any system that is developed to ensure that therapists are competent should be transparent, practical and robust. How the competence of the individual is assessed is seen as crucial and should include an external element as part of verification of evidence. Some form of regular formal assessment would be strongly supported and the assessment should cover both tasks and background knowledge.

Areas of commonality

35. As identified in the mapping exercise, the codes of conduct and standards of practice form the professional framework within which members are expected to work. These are a strong common base which could provide a starting point for developing a consensus view on the nature of professional competence and a common framework for an outcomes based approach from which profession specific models could then be developed.

36. The central themes identified within this professional framework combined with the common themes relating to competence and CPD accord strongly with the government's agenda (DoH, 2000a; DoH, 2000b; DoH, 2001a; DoH, 2001b; DoH, 2001c; Sc.Exec., 2000; Na.Ass.Wa., 2001) of wanting to ensure that:

- professionals have the skills to do the job
- the service is based on up to date evidence and best practice
- professionals collaborate freely and communicate effectively for the good of the patient
- professionals learn from day to day practice
- services are client focused and needs led
- clinical audit is used to inform improvements in service

37. The wide range of material provided by the professions demonstrates their commitment to promoting and maintaining high standards of practice. Of particular relevance is the development of approaches to CPD and a range of supporting materials and tools. Supporting members in demonstrating their competence is seen as a key role of the professional bodies.

38. Within the consultation the professions expressed an enthusiasm for the project and a willingness to work together and share information and expertise to the benefit of the project. As a group they are keen to see the development of a holistic approach that:

- Is inclusive of all roles, level and context in which individuals work
- Is realistic, simple and practical
- Has a clear structure and is applicable to other systems e.g. appraisal
- Encourages a broad range of CPD activities.
39. There is a common interest in developing a practical framework that can be grounded in day to day practice but which recognises the complexity of this and the varying contexts in which members work. Reflective practice is seen as a crucial element by all of the professions and while work has already been done in this area it is hoped that the project will develop this further.

40. The work and thinking already done by the professions on CPD and tools provides a common base from which to draw ideas and feed into the project and develop further.

**Strengths on which project can build**

41. One of the key strengths of the project, recognised by both the individual professions and key stakeholders, is its multi-professional nature. It will allow professions to continue to share expertise, knowledge and relevant pieces of work that will support the development of the project as well as work within the individual professions. While recognising the complexity of the issues involved it provides an opportunity to develop a common understanding of these, in particular professional competence, CPD and the links between the two.

42. The project can build on the strong common base identified within the codes of conduct and standards of practice and on work already done by the professions in developing approaches to CPD. Alongside this is the professions’ willingness to support change; a number of the codes and standards have been revised in recent years and now include references to competence, CPD, Life Long Learning, quality and audit, evidences-based practice and collaborative working.

43. The aims of the project accord strongly with the government’s agenda, demonstrated by the strong sense of commitment from the professions to promote and maintain high standards of care. This is supported by the central themes identified within the professions Codes of Conduct and Standards of Practice, along with a wide range of additional material.

**Areas for development**

44. In taking the project forward opportunity needs to be given to

- Developing a common understanding of professional competence, CPD, links between competence and CPD and an outcomes based approach
- Exploring how an input approach to CPD will fit within an outcomes based approach
- Considering whether it is feasible and or desirable to establish minimum requirements for demonstrating competence.

45. The central themes identified from the codes of conduct and Standards of Practice could be used as the basis for developing ideas around the common framework and ideas of professional competence.

46. Discussion about the above should enable the professions to develop their thinking regarding these conceptual ideas, which should then feed into developing and building on ideas related to the following:

- Tools to assist professionals explain their practice
- How to allay members’ anxieties/fears about demonstrating competence
- Peer review
- Developing/identifying learning outcomes
- Reflective practice
- Role of supervision/appraisal/Personal Development Plans/Individual Performance Review
- Developing self-awareness through reflective practice.
47. The promotion of work based learning, both individually and within teams together with the development of tools to support this (e.g. audit) needs to be developed. Along side this is a need to look at what evidence will look like and how it will be assessed and verified.

Summary

48. It is clear that the professions have a strong common base, stemming from the central themes of the professional framework from which to work. This is further supported by the development of underpinning material, in particular relating to CPD and a range of tools.

49. There is an enthusiasm and commitment from all of the professions involved to promote high standards of practice and a quality service to clients. This is reflected in their willingness to review and explore relevant approaches and to ensure that these are in line with the changing context in which members work.

50. It is recognised that the multi-disciplinary nature of the project is a key strength and a key driver for involvement in the project is the wish to influence the HPC’s thinking relating to re-registration requirements.

Dawn Wheeler
Fieldwork Officer AHP Project
18 March 2002

References


Appendices [available on request]
1 Briefing paper
2 List of people interviewed
3 Questions for initial consultation
4 List of requested material
5 List of materials received
6 Approaches to CPD
7 CPD activities
8 CPD tools
Material requested for initial mapping exercise

It is requested that professional bodies provide documentation on the following to ensure the effective induction of project staff and to inform the initial stages of the project:

- CPD/lifelong learning policies
- CPD/lifelong learning tools (e.g. learning portfolios or reflective journals)
- Guidance papers on issues relating to CPD/lifelong learning:
  - Reflective practice
  - Mentorship
  - Clinical supervision
  - Work-based learning
  - Personal development plans
  - Appraisal
  - The range of CPD/lifelong learning activities
  - Accredited programmes
- Existing CPD/lifelong learning requirements and related monitoring schemes
- Evaluations of the operation of CPD/lifelong learning requirements where operated (e.g. on compliance levels or analyses of member perceptions of such schemes)
- Project reports relating to CPD/lifelong learning and/or competence
- Policy statements on professional competence issues
- Professional competence tools (e.g. statements of expectation)
- Guidance materials for members of the profession acting in support of practice-based learning (e.g. as clinical/fieldwork educators)
- Guidance materials for members returning to professional practice after a career break
- Rules of professional conduct
- Statements about/advice on scope of practice issues
- Standards of practice
- Guidance papers or policy statements on issues such as
  - Clinical audit
  - Using outcome measures
  - Clinical guidelines
  - Using other evidence-based practice tools
- Information on professional networks (e.g. clinical interest/occupational groups / regional networks) that could helpfully be used within the project
- Any other materials (whether policy statements, tools or project reports) deemed relevant by each professional body to the project
Questions for initial consultation

The schedule of questions was developed to provide a framework for the consultation interviews, ensuring that key topics were covered and that the information gathered during the consultation exercise was comparable. They were amended for the various groups as follows:

Professional Body Representatives
- What are your expectations of the project?
- How do you think it relates to work that your profession has done?
- What is your understanding of an outcomes-based approach?
- How would you define professional competence?
- How would you define CPD?
- What do you see as the links between competence and CPD/lifelong learning?
- What concerns/issues do you have that you are keen to pursue within the project?
- How do you see the next ‘developmental’ stage progressing?
- Do you think that the 6 outcomes identified within the CSP’s draft model are broadly transferable to your profession?
- What are your initial thoughts on how they would need to be developed, or what would need to be in their place?

Health Professions Council
- What do you see as the main drivers/aims of HPC introducing re-registration requirements?
- What do you see as the links between professional competence and CPD?
- What is your understanding and expectations of the project?
- What is your understanding of an outcomes-based approach?
- What sort of framework do you think HPC might be looking for?
- How transferable do you think the draft CSP outcomes-based model is across the Allied Health Professions?
- What particular issues are you keen to see covered by the project?
- What do you see as the strengths of the project?
- What is the best way to maintain links and consult with HPC beyond the links established through the steering group?

Department of Health
- How would you define professional competence?
- How would you define CPD?
- What are your expectations of the project?
- What particular issues are you keen to see covered within the project?
- What do you see as the main strengths of the project?
- What other projects do you think it would be useful to look at that might link in with this piece of work?
- How transferable do you think the draft CSP outcomes-based model is across the Allied Health Professions?
- What is the best way to consult with and keep the Department of Health informed outside of the links established in the Steering Group?

User representative
- How would you define professional competence?
- How would you define CPD?
- What is your understanding of an outcomes-based approach to demonstrating competence through CPD?
- What do you think the project should be seeking to achieve?
From your organisation’s perspective, what are the priorities and main issues that need to be attended to in the future introduction of re-registration requirements for the allied health professions?

What particular issues are you keen to see covered within the project?

What do you see as the main strengths of the project?

How might we involve your organisation in the project as work progresses?

Dawn Wheeler
Fieldwork Officer AHP Project
18th March 2002
Appendix VII

Development of the draft profession-specific models

A package of information was produced to facilitate the preparation of draft profession-specific models. In addition to including the working version of the common framework [see Annex A] and the generic outcomes model [see Annex B], the pack included the following:

- Frequently-asked questions [to help pre-empt issues about which representatives of each professional body might have queries]
- A set of questions to help professional body representatives critique and refine their draft profession-specific model.

Both the above are provided in this appendix.

Frequently-asked questions

This sheet seeks to clarify thinking behind the draft, generic model and its development.

**Couldn't the model be simpler?**

There are approaches to recording CPD activity that are simpler (e.g. ones that focus on the number of hours’ activity or the types of activity completed) and approaches to competence that are more straightforward (e.g. that focus on the successful completion of tasks or that are based on detailed descriptions of appropriate practice). However, it seems more helpful to take an approach that explicitly

- Seeks to help individuals make links between their learning activity and their on-going professional competence;
- Recognises and respects the complexity and distinctive nature of individuals’ competence.

In developing the model, efforts have been made to produce a tool that, while being based on quite complex concepts, is relatively straightforward to use.

**Won't using the model take up a lot of time?**

Feedback from CSP members who took part in an initial pilot exercise of a model developed for physiotherapists indicated they spent varying amounts of time on getting to grips with the materials and writing outcome statements: some took between one and two hours; others twelve. While it may take some time to become familiar with the model, the process of compiling statements should become quicker as individuals use the materials more frequently. The feedback also suggests that using the model should be useful for completing other tasks (e.g. preparing for an annual appraisal session).

**Are the outcomes really about competence?**

The AHPs believe collectively that it is important to highlight the skills of assessment, evaluation, professional judgement and decision-making, as well as the ethical and emotional dimensions of practice, in defining professional competence. Not to do so risks undervaluing and misrepresenting what individual AHPs do.

The draft model reflects current thinking on what competence for professionals, and those working in health care in particular, is really about and how this is best defined, demonstrated and verified.

The outcomes give pre-eminence to attributes that are seen as central to what AHPs do and try to avoid the pitfalls of taking a simple approach that risks seeing competence purely in terms of easily observable knowledge and skills. To the fore within the draft model is the sense that competence is about

- Self-awareness about personal scope of practice, knowing the boundaries of this and how it relates to the broad terrain of the profession;
- Recognising that professionals don’t work in isolation;
- Recognising that professional practice is not just about the application of knowledge and skill;
More than being safe – effective practice is also a vital element.

The approach also seeks to recognise that the professional practice of individuals and the practice of professions are constantly changing; to try to pin down competence in tight definitions would have a limiting effect on individuals’ and professions’ development. It therefore places a strong focus on effective decision-making and the exercise of due discretion as essential features of professional practice.

How is the model useful for CPD?
The draft model has been designed to help individuals plan, structure and reflect on their CPD. The prompt questions should be particularly helpful in this respect. The model promotes the approach to CPD that many of the AHPs have been advocating for some time. This is based on the principles that

- Individuals’ CPD activity should be planned and evaluated in line with identified learning needs, interests and goals;
- Professional development occurs primarily through day-to-day practice and reflecting on learning achievements and on-going learning needs;
- Individuals have diverse and changing learning needs as they progress through their career.

The most important thing is what individuals learn and how they apply their learning to their practice, rather than the number of hours they might spend on their learning or how many courses they attend. An outcomes-based approach to CPD, which the draft model represents, also accords strongly with the government’s quality initiative, clinical governance.

Evaluation gained through the CSP’s initial pilot exercise indicated physiotherapists found using the model particularly helpful for structuring and reflecting on their CPD.

What are the links between competence and CPD?
The relationship between competence and CPD is difficult to define and prove. However, there is a need to try to establish and demonstrate the links, not least because future statutory re-registration requirements will demand they are made. The outcomes model should enable AHPs to demonstrate their competence through evidence of their CPD. With its intended encapsulation of the agreed characteristics of the professional competence for each profession (achieving this through appropriate development and refinement is the main purpose of the current exercise), it should provide individuals with the structure to explain

- What they have learned;
- How their practice has developed as a result of their learning;
- The impact and benefits of their learning and development on their practice and contribution to service delivery.

In this way, it should enable individuals to provide a robust and convincing testament of their on-going safety and effectiveness.

How does the model relate to non-clinicians?
The model has been designed to be as relevant to AHPs working primarily in non-clinical roles – for example, as a manager, educator or researcher – as it is for those whose professional role revolve around clinical practice. The outcomes, explanatory notes and prompt questions have the breadth to apply to non-clinical practice, while the fictitious case scenarios stress the importance of professional activity relating to education, research and management, while focusing on professional roles that are not purely or at all clinical in their focus.

How does the model fit with existing procedures?
Reflecting on practice in a structured and relatively formal way is something individual AHPs are likely already to do for other purposes. If they work in the NHS, their employer should by now have issued them with a personal development plan, or PDP. Individuals in all employment sectors may already keep a professional diary, log or portfolio, perhaps provided by their employer or department, professional body or any clinical interest or occupational groups to which they belong. Individuals may
be asked to draw material from personal documentation for their annual, or bi-annual, appraisal sessions. The outcomes model should complement these kinds of exercises, rather than requiring something that is radically new.

**How does the model fit with professional bodies’ existing CPD policies?**
As the outcomes-based approach is designed to offer a structure of CPD, it is important that appropriate links are made with related materials and tools already in place. Although development of the profession-specific models will be based on the parameters set by the draft common framework, it is anticipated that they will relate to existing CPD policies. (Indeed, strong account has been taken of such scheme and policies, along with other materials, in drafting the framework itself.)

The profession-specific models will need to be underpinned by a variety of material, including a profession’s code of conduct and standards of practice; relevant policies relating to post-qualifying learning and practice’ and CPD schemes and tools. It is expected that these types of materials will be highlighted in the profession-specific models to supplement the support provided to individual users and to put each model in its appropriate professional context.

**How will individuals’ evidence be verified?**
The project is seeking to secure an appropriate influence over how statutory re-registration requirements are developed and implemented by the new Health Professions Council (HPC). It is doing this by formulating profession-specific models for demonstrating competence through CPD, each of which sit within a common framework. The focus of the project is therefore on developing a sound conceptual base and manageable and robust practical tools for making tangible links between individuals’ CPD activity and their on-going competence.

The project’s pilot stage will allow exploration of the range of ways individuals can provide evidence in support of their reflective statements on how they have fulfilled a series of profession-specific outcomes. It is intended that this will take a lateral approach, testing how evidence can be provided that is grounded in day-to-day practice. However, it is not within the scope of the project to develop processes through which this evidence can be verified. The reasons for this are

- The wish to focus on developing a secure conceptual and practical foundation for demonstrating competence through CPD, rather than the mechanics through which such demonstration is verified – this is seen as something to be addressed directly once the foundations for the approach have been laid;
- Current uncertainty over how and when the HPC will introduce and implement re-registration requirements (it is understood that issues relating to this will be raised in the Council’s imminent consultation exercise);
- Related uncertainty as to whether the HPC will seek to delegate some responsibility for monitoring compliance with its requirements to the professional bodies (if it does, this will be something for each organisation to consider, rather than something that can be explored on a collective basis).

Developments affecting other professional groups (for example, the medical profession) may be relevant in how AHPs’ fulfilment of re-registration requirements are verified. The project steering group includes representatives of the health and social care regulatory bodies, in addition to the HPC, who can advise on possible parallels.
**Introduction**

We are now seeking your views as to whether you feel the attached draft model needs to be developed or changed further for adoption by … wherever they practise. The model will be piloted alongside other Allied Health Professions’ models later this year.

The questions below focus on the key elements of the model, but you are invited at the end to add any additional comments that you may have.

1. Focusing on the key elements of the model, what changes or additions (if any) need to be made to the following? (either complete the boxes below or insert your comments directly into the document using the tracking mechanism under tools):

   a) opening guidance?

   b) the outcomes (in order to encapsulate the nature of competence for your profession)?

   c) explanatory notes (to highlight issues of particular importance to the profession)?

   d) prompt questions?

   e) support materials (to highlight professional body materials of particular relevance to individual’s fulfilment of each outcome)?

   f) summary checklists?

2. Focusing on the case scenarios do they:

   a) cover a broad enough range of career stages? YES / NO

   If NO how would you develop this section further?

   b) offer credible coverage, through the range of examples provided, of the … profession? YES / NO

   If ‘NO’, how do the examples need to be developed and why?
c) offer sufficient support, alongside the prompt questions, to enable users to demonstrate fulfilment of the outcomes?  
YES/NO

If ‘NO’ how would you develop this section further?

3. What further amendments are required (if any) to ensure that the model is inclusive of all … wherever they practise?

4. Any other comments:

Thank you for your time in completing this questionnaire.
Appendix VIII

Criteria for pilot sites and their selection

Expectations of pilot sites and participants

A pilot site should

i. Contain a minimum of one member of one of the participating professions (there is no set maximum for the number of individuals involved in any one site);

ii. Contain a minimum of representation from one of the participating professions (there is no set maximum for the number of participating professions involved in any one site);

iii. Indicate a formal interest in participating in the exercise through completing and returning the expression of interest form;

iv. Provide confirmation of approval for the participants’ involvement in the exercise from an individual with appropriate authority;

v. Provide information on the profile of participants involved through the formal registration process;

vi. Appoint an individual or individuals willing to act in a co-ordinating role;

vii. Be willing to send representatives to an initial regional event.

Pilot participants should

viii. Be willing to work with the draft outcome model developed for their profession for two months within the three-month pilot exercise period;

ix. Be willing to submit feedback on their experience through completing evaluation forms (and, where possible, attending a concluding regional workshop);

x. Be willing to submit anonymous outcome statements and supporting evidence for analysis.

Selection of pilot sites

Pilot sites have been selected so that, collectively, they fulfil the criteria given below.

The total configuration of pilot sites includes

xi. Representation from each of the participating professions, seeking to gain a reasonable balance of representation from each but accepting that numbers may be greater from some professions than others;

xii. Representation from members of the allied health professions [AHPs] from each career stage (including the newly-qualified, those having a career break, recent returners and those nearing retirement);

xiii. Representation from members of the AHPs in all occupational roles (broadly definable as clinicians/practitioners, managers, educators and researchers and recognising that a significant proportion of members fulfil a combination of roles);

xiv. Representation from members of the AHPs practising in all employment sectors (including public, private, independent, and voluntary);

xv. Representation from members of the AHPs practising in all employment settings (including those involving working in large uni-professional departments, multi-professional units, under inter-agency arrangements and as sole practitioners);

xvi. Representation from members of the AHPs at all career grades (ranging from junior posts to specialist/consultant/leadership roles);
xvii. Representation from members of the AHPs practising in a broad range of geographical settings (ranging from major conurbations to isolated rural areas);

xviii. Representation from members of the AHPs across the UK, ensuring a good geographical spread of participants;

xix. Representation from members of the AHPs with differing levels of exposure to other approaches to professional competence initiatives and differing levels of involvement in structured approaches to CPD;

xx. Representation of individuals involved in related pilot initiatives (specifically the early implementation of the Knowledge and Skills Framework in the NHS in England, the Department of Health’s initiative for modernising health care education, and the CPD framework of the Institute for Teaching and Learning and any other agreed by the project steering group).
Appendix IX

AHP project: Demonstrating competence through CPD
Pilot Exercise – November 2002 to February 2003

Evaluation Form

1. Have you found the material provided to you as a pilot participant easy to understand?
   
   Yes   
   No

2. If you have answered ‘No’, what did you find difficult? If you have answered ‘Yes’, please move to question 3
   
   

3. How useful did you find the support material?

<table>
<thead>
<tr>
<th>Element</th>
<th>Very useful</th>
<th>Useful</th>
<th>Not useful</th>
<th>Didn’t use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guide for pilot participants</td>
<td></td>
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</tr>
<tr>
<td>Introductory elements of the draft outcomes model</td>
<td></td>
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</tr>
<tr>
<td>Explanatory note to each outcome within the draft model</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prompt questions within the draft model</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggestions of further material to consider</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fictitious case scenario pack</td>
<td></td>
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</tbody>
</table>

4. How do you think the support material could be improved?

5. Did you find it easy to relate each of the outcomes to your practice?

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Outcome 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome 3</td>
<td></td>
<td></td>
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<tr>
<td>Outcome 4</td>
<td></td>
<td></td>
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<tr>
<td>Outcome 5</td>
<td></td>
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</tr>
<tr>
<td>Outcome 6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome 7 [for art therapists only]</td>
<td></td>
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</tr>
</tbody>
</table>

6. If you have answered ‘No’ or ‘Not sure’ to any or all of the above, what did you find difficult? [please refer to specific outcomes if necessary]. If you have answered ‘Yes’ to all of question 5, please move to question 7

   

7. Do you think the outcomes in their entirety provide a full, accurate and concise description of the competence of members of your profession?

   Yes   
   No   
   Don’t know

8. If you have answered ‘Yes’ to question 7, please move to question 9. If you have answered ‘No’ or ‘Don’t know’ to question 7, what do you think is

<table>
<thead>
<tr>
<th>Please explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing?</td>
</tr>
<tr>
<td>Misrepresented?</td>
</tr>
<tr>
<td>Superfluous?</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

9. Do you think it would be possible for someone to demonstrate fulfilment of the outcomes without being what you would define as ‘competent’?

   Yes
   No
   Don’t know
DRAFT FOR COMMENT ONLY, NOT FOR CIRCULATION

10. If you have answered ‘Yes’ or ‘Don’t know’ to question 9, what are your concerns about how the outcomes define competence? If you have answered ‘No’, please progress to question 11.

11. How did the draft model help you take a structured approach to your CPD?

<table>
<thead>
<tr>
<th>For example, by making you think more about</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your recent practice and learning</td>
<td></td>
</tr>
<tr>
<td>What you have achieved</td>
<td></td>
</tr>
<tr>
<td>How you want to develop in the future</td>
<td></td>
</tr>
<tr>
<td>Other [please state]</td>
<td></td>
</tr>
</tbody>
</table>

12. Do you think the outcomes could be developed to support your CPD more effectively?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
</table>

13. If you have answered ‘Yes’ to question 12, how do you think the outcomes could support your CPD more effectively? If you have answered ‘No’ or ‘Don’t know’, please move to question 14.

14. How long did you spend reading through the materials and thinking about how they relate to your practice?

15. How long did you spend compiling your outcome and summary statements?

16. How long did you spend compiling evidence in support of your statements?

17. How useful did you find any support that you sought during the pilot exercise?

<table>
<thead>
<tr>
<th>Type of support</th>
<th>Very useful</th>
<th>Useful</th>
<th>Not useful</th>
<th>Didn’t use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pilot induction workshop</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice from site co-ordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice from professional body representative</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Advice from project team</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

18. Did your involvement in any of the kinds of schemes or initiatives listed below help you to prepare your outcome and summary statements and supporting evidence?

<table>
<thead>
<tr>
<th>Type of scheme/initiative</th>
<th>✓</th>
<th>Type of scheme/initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning portfolio</td>
<td></td>
<td>Nationally-set CPD requirements</td>
</tr>
<tr>
<td>Personal development plan</td>
<td></td>
<td>Locally-developed competence framework</td>
</tr>
<tr>
<td>Annual appraisal</td>
<td></td>
<td>Nationally-developed competence framework</td>
</tr>
<tr>
<td>Locally-set CPD requirements</td>
<td></td>
<td>Other [please state ……………………….]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Biographical and other background information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which professional body do you belong to?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Profession</th>
<th>✓</th>
<th>Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association of Professional Music Therapists</td>
<td></td>
<td>Chartered Society of Physiotherapy</td>
</tr>
<tr>
<td>British Association of Art Therapists</td>
<td></td>
<td>College of Occupational Therapists</td>
</tr>
<tr>
<td>British Association of Dramatherapists</td>
<td></td>
<td>Institute of Biomedical Science</td>
</tr>
<tr>
<td>British Association of Prosthetists &amp; Orthotists</td>
<td></td>
<td>Royal College of Speech &amp; Language Therapists</td>
</tr>
<tr>
<td>British Dietetic Association</td>
<td></td>
<td>Society of Chiropodists &amp; Podiatrists</td>
</tr>
<tr>
<td>British Orthoptic Society</td>
<td></td>
<td>Society of Radiographers</td>
</tr>
<tr>
<td>British Paramedic Association</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
20. In which setting do you predominantly work?

<table>
<thead>
<tr>
<th>Setting</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS acute trust</td>
<td>Occupational health</td>
</tr>
<tr>
<td>NHS primary care trust</td>
<td>Higher education</td>
</tr>
<tr>
<td>NHS mental health trust</td>
<td>Research</td>
</tr>
<tr>
<td>GP practice</td>
<td>Voluntary sector</td>
</tr>
<tr>
<td>Social services</td>
<td>Secure sector</td>
</tr>
<tr>
<td>Private practice</td>
<td>Other [please state ..............]</td>
</tr>
<tr>
<td>Independent hospital</td>
<td></td>
</tr>
</tbody>
</table>

21. Which of the following best describes your employment status?

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Employment status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time</td>
<td>Locum</td>
</tr>
<tr>
<td>Part-time</td>
<td>Career break</td>
</tr>
<tr>
<td>Self-employed</td>
<td>Retired</td>
</tr>
<tr>
<td>Sessional</td>
<td>Other [please state ..............]</td>
</tr>
</tbody>
</table>

22. Which of the following best describes your career stage/role?

<table>
<thead>
<tr>
<th>Professional experience</th>
<th>Professional experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recently-qualified</td>
<td>Manager [multi-professional]</td>
</tr>
<tr>
<td>Experienced clinician</td>
<td>Educator</td>
</tr>
<tr>
<td>Specialist clinician</td>
<td>Lecturer-practitioner</td>
</tr>
<tr>
<td>Extended scope practitioner</td>
<td>Researcher</td>
</tr>
<tr>
<td>Consultant therapist</td>
<td>Researcher-practitioner</td>
</tr>
<tr>
<td>Clinician-manager</td>
<td>Independent consultant</td>
</tr>
<tr>
<td>Manager [uni-professional]</td>
<td>Other [please state ..............]</td>
</tr>
</tbody>
</table>

23. How long have you been qualified?

<table>
<thead>
<tr>
<th>Number of years</th>
<th>Number of years</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>16 – 25</td>
</tr>
<tr>
<td>6-15</td>
<td>26 or more</td>
</tr>
</tbody>
</table>

24. How would you describe your previous involvement in structured approaches to CPD?

<table>
<thead>
<tr>
<th>Previous involvement</th>
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<tbody>
<tr>
<td>Very involved</td>
<td>Not very involved</td>
</tr>
<tr>
<td>Quite involved</td>
<td>Not at all involved</td>
</tr>
</tbody>
</table>

25. How would you describe your awareness prior to your involvement in the pilot of approaches to/frameworks for professional competence

<table>
<thead>
<tr>
<th>Previous awareness</th>
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<tbody>
<tr>
<td>Very aware</td>
<td>Not very aware</td>
</tr>
<tr>
<td>Quite aware</td>
<td>Not at all aware</td>
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</tbody>
</table>

26. Any other comments – please use the box below to give any other feedback on your involvement in the pilot exercise

Thank you very much for participating in the pilot exercise. Please complete this form and return it, along with your statements and evidence, by 14 February 2003 to Sheila Christie, AHP project administrator, Chartered Society of Physiotherapy, 14 Bedford Row, London, WC1R 4ED. Please contact Sheila Christie before 14 February if you would like to receive this form by email so you can complete and return it electronically [christies@csp.org.uk].
Allied Health Professions [AHPs] Project: 
Demonstrating competence through CPD

Briefing paper for consultation to gain users’ perspectives

Introduction to the project and why has it come about?
The Department of Health in England was keen to work with AHPs to find a way of showing the public that the services they deliver are safe and effective. At the moment there is no mandatory requirement for AHPs to keep their skills up-to-date. However, this will change in about three years time, when the new Health Professions Council [HPC] introduces re-registration requirements. The results of the project will be part of the information used by the HPC to decide on the best way to move forward with these requirements as an important way in which it strengthens its public protection role.

Part of being a professional is the responsibility it places on each individual practitioner to make sure they only work in the areas they are competent, that they keep their knowledge and skills up-to-date and that they place patient care and safety at the centre of their practice. It was agreed amongst the 14 AHPs involved in the project to look at how an outcomes-based approach to demonstrating competence through continuing professional development [CPD] could do this.

Who are Allied Health Professionals [AHPs]?
‘AHPs’ is the new collective name for the professions allied to medicine [PAMs]. You will know many of them most commonly as ‘therapists’ (i.e. arts therapists, occupational therapists, physiotherapists and speech and language therapists), but they also include dieticians, paramedics, podiatrists/chiropodists, radiographers (diagnostic and therapeutic), orthoptists, biomedical scientists, clinical scientists, prosthetists and orthotists.

What does ‘outcomes model’ mean?
The term ‘outcomes’ refers to what has been learnt by the individual in terms of their skills, behaviours and how they do their job. The participating professions have agreed on 6 outcomes that they feel describe what it is to be a competent practitioner. The outcomes are intentionally broad because members of the AHPs work in many different settings and sectors (e.g. hospitals, schools, patients’ homes, industry, etc.), work with different types of people, take on different roles (e.g. clinician, teacher, manager, researcher, etc.) and have to cope with constant change, with advances in health care provision and changing patient need.

What are the outcomes?
The six outcomes around which the draft project materials revolve are as follows:

- Understand, work within and respond to the limits of professional practice
- Demonstrate effectiveness in practice
- Practise within your profession’s moral and ethical framework
- Think critically about personal practice and its context
- Deal appropriately with the new and non-routine
- Communicate and collaborate effectively

The art therapy model currently includes a seventh outcome that stresses the importance of delivering services that are sensitive to cultural diversity and that comply with legislation relating to ensuring equality and anti-oppressive practice. Work is currently being done to integrate these values within all the models and give them due prominence.

How does it show that AHPs are competent?

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1 This briefing paper was also made available in a large-type format.
The outcomes model focuses on what individuals have learnt and how it has affected their practice and service delivery. Within many approaches to CPD, there is a tendency to focus on attending courses and formal training, or the number of hours spent on learning. While these issues are important, thinking behind the project is that what is really important is what each individual learns from their CPD, whatever activities this activity takes, and how they put this learning into practice to enhance patient/client care and service delivery.

Most AHPs’ jobs are very practical, so on-the-job learning and the constant review of how effective they are in their role plays a crucial part in developing their skills. Individuals bring together the informal and formal activities they have been doing, in written statements and with supporting evidence, to cover each of the above outcomes. Most importantly, however, it is in the context of their individual practice that they need to show that they are working safely and effectively.

How is it being tested?
A pilot exercise was set up at the end of the summer 2002 to test the draft models and supporting materials with AHP members from 50 pilot sites across the UK. They were asked to submit statements with supporting evidence covering all the outcomes. They were also asked to fill in an evaluation form to indicate how they found the experience of using the materials.

The response rate of 61% has been every encouraging, with just over 800 submissions and 600 personal statements available for analysis.

The pilot exercise deliberately did not test out possible mechanisms for monitoring or verifying how individual practitioners demonstrate their fulfillment of the outcomes. However, it is planned that this area will form the focus of activity if further project work is commissioned.

What stage is the project at?
The project is currently at the evaluation stage. This is involving analyzing the submitted statements and evaluation forms by the project team and representatives of each of the participating professions. This process will be used to develop and refine the draft models and supporting materials.

A consensus-building conference on the project is being held on 15th May in Birmingham, the purpose of which will be to bring together representatives of organizations with an interest in the project’s activity, what it recommends, and what proposals for further work may be made.

A final report will be produced at the end of June 2003. This will identify

- recommendations for the way forward
- issues requiring further work
- an evaluation of how the project has been carried out

What benefits should the approach have for you and other service users?
The approach developed within the project should provide an additional measure through which you will be able to trust that you are receiving safe and effective treatment. It is based on agreed professional standards, links into many other initiatives and tools delivered at a local level and fits with broad policy initiatives concerned with enhancing patient/client care and service delivery.

How can you give your opinion of the project and its aims?
The project would welcome any feedback that you may wish to make, either by email, in writing or by telephone. The following list of questions may provide a helpful framework for your comments. The project team may contact you, with your permission, to follow up particular comments.

- Do you think the outcomes taken together describe the qualities of a competent health care professional? What is missing or not required?
• If you knew a member of the AHPs had shown evidence of fulfilling the outcomes, would that be enough to give you confidence in their practice?
• What improvements and/or changes would you suggest?
• Are there any issues that you or your organisation would like to see explored further?
• What do you think about how the project is testing the model - is it rigorous enough to make you feel confident that the results will be reliable?
• Would you like to be involved in the consensus-building conference [15th May in Birmingham]?

Contacts for comments: Sheila McEwan, Project professional adviser; email:mcewans@csp.org.uk; Tel no.01292315084
c/o, Sheila Christie, APH Project administrator, Chartered Society of Physiotherapists, 14, Bedford Row, London WC1R 4ED
Fulfilment of outcomes = Demonstration of competence

Evaluation

Identification of learning needs

Joint KSF review

KSF PDP

Undertake learning & development

Synthesis of learning, involving critical reflection on learning achieved and relevant to practice

Application to practice

Evaluation

Action plan

CPD activity

Links between KSF & outcomes model

Appendix XI