Continuing Professional Development (CPD) Engagement – A UK-based Concept Analysis

Abstract

Introduction: Although much literature exists regarding the operationalization of the term engagement, this relates specifically to work/employee engagement and user, consumer, and scholarly engagement. There is no clear understanding of the term Continuing Professional Development (CPD) engagement for allied health professionals and Nurses and Midwives in the UK, although it is becoming a frequently used term. This raises the challenge of creating measures of the impact of CPD engagement. This concept analysis therefore sought to operationalize the term CPD engagement.

Methodology: A theoretical concept analysis was undertaken, as part of a Professional Doctorate, using Walker and Avant's Concept Analysis Framework. Literature was accessed via OVID, PubMed, CINAHL, ERIC, ABI INFO, and PsychINFO using search terms *engagement*, *work/employee*, *user*, *consumer*, *scholarly engagement*, *CPD*, and *life-long learning*.

Results: Defining attributes for CPD engagement included criteria based around the terms such as self-initiated, voluntary, applied, recorded, evaluated and shared, and continuation of learning beyond the initial activity. Antecedents focused around drive and availability of resources including time, money, and support.

Conclusion: There are potentially many positive consequences of CPD engagement, such as job satisfaction, employee retention, and quality of service provision, that may be more easily investigated and measured against the attributes defined from

this study, which indicates that CPD engagement is characterized by the following five criteria: 1) self-initiated; 2) rewarded (either intrinsically or extrinsically); 3) applied in practice; 4) recorded, evaluated, and shared with others; and finally 5) continues beyond the initial learning activity.

Introduction and Background

Continuing Professional Development (CPD) has been elevated in status in recent years and is now mandatory (required for registration and practice) for all qualified health professionals in the UK.[1-4] Since 2001, when the Department of Health acknowledged its importance, CPD has been considered to be an essential and complex concept[5,6] that can assure high-quality care within health and social care.[7,8]

The importance of CPD was highlighted by Guskey in 1986,[9] who stated that high-quality staff development was thought to be the most important factor in the improvement of education. In recent years, much of the literature pertaining to health and care suggests that although people believe CPD to be essential and effective in driving quality of care,[7,8] there is little measurement of its effectiveness on patient outcome for the allied health professions (AHP) and Nursing and Midwifery[1,10,11] Several studies have, however, been undertaken in dentistry[12] and medicine, most notably a systematic review by Cervero and Gaines[13] that demonstrated positive links between continuing education and physician performance and, to a lesser extent, patient outcomes. They did, however, stipulate the presence of several conditions for this to occur, including the need for multiple and longer exposures to CPD and a focus on outcomes considered important by the physician. Although this

review does not explore CPD engagement in the medical context, these factors are reflected in the defining attributes presented.

CPD has long been seen as pivotal in the development of the professional knowledge base alongside the maintenance of autonomous practice, competency, and accountability.[2,14-18] Standards developed for professional regulation in the AHPs and Nursing and Midwifery more recently highlight the importance of *engagement* in CPD as critical, with regulators developing standards requiring registered professionals to demonstrate that they are actively undertaking and applying their learning from CPD.[2,18] Despite its inclusion in the regulations for both groups of professionals, the concept of CPD engagement is not clearly defined, making accurate measurement of success of engagement in terms of patient outcomes difficult.

Concepts and their clarification are essential in developing foundations for theoretical frameworks that apply to all professions, including those in health and social care.[19] Concept analyses draw together the core attributes of a specific notion, facilitating its understanding and distinguishing it from other comparable concepts.[20,21] This clarity, achieved by critiquing current literature regarding the positive concept and its negative opposite, is essential if research is to be meaningful.

This article analyzes the concept of *CPD engagement* for AHPs and Nurses/Midwives to promote mechanisms for encouraging CPD engagement with a goal of facilitating measurement and support future research. These two professional

groups have been selected because they jointly formulated their guidance for CPD in the UK in 2007[22] which was collaboratively re-written this year.[23]

Concept Analysis Methodology

Within health and care, concept analyses are increasing in popularity,[24,25] and many authors have highlighted their importance in helping to develop clarity of understanding of concepts and theoretical frameworks.[20,26-28] At this point it is important to acknowledge that despite the acceptance of concept analyses, not all value them as a valid and reliable tool for the purpose of developing operationalized definitions for research.[29] This is due to the perceived lack of empirical research and systematic searches involved. This criticism informed the choice of Walker and Avant's[20] eight stage model for this concept analysis, which is acknowledged to provide a more systematic approach to developing an understanding of concepts, specifically in nursing and health care,[30] and has proved a useful mechanism to explore and clarify the meaning of CPD engagement within this health care context.

Walker and Avant's model (1995),[20] which was selected to facilitate this process of concept clarification, identifies eight stages that are important to follow in organizing and developing a concept analysis, namely

1) Select the concept to be analyzed
2) Determine the purpose of the analysis
3) Identify the uses of the concept (as reflected in current literature)
4) Identify the defining attributes
5) Describe a model case reflecting all attributes of the concept
6) Describe contrary, related, and borderline cases

7) Identify antecedents and consequences
8) Define empirical referents

Walker and Avant's[20] model highlights the need to explore *positive psychology*,[31] referring to the need to develop a greater understanding of the nature, antecedents, and consequences of CPD engagement rather than purely exploring why people do not engage. This helps to promote an understanding of the concept in greater depth by identifying all factors that contribute to CPD engagement.

There are two main types of concept analysis, theoretical and colloquial.[29] Within this article, *theoretical*[29] concept analysis (defined through critique of the literature) has been used for the clarification of the concept of CPD engagement, although the use of some colloquial evidence is recognized, namely when the literature has uncovered studies that have investigated perceptions of health professionals believed to be engaging in CPD [5,6]. Within a theoretical analysis, where a variety of disciplines (in this case AHPs and Nursing and Midwifery) embrace the concept, evidence as to its interpretation should be integrated accordingly while recognizing where context may impact upon the way the concept is interpreted/used.[29] Derrida (1978 cited in Beckwith)[24] stressed that it is also important to note that words may have two or more meanings, and the meaning adopted may change the resulting analysis. For example, the word *stress* can refer to a feeling of anxiety or the act of accentuating something. Walker and Avant[20] therefore emphasize the need to investigate possible interpretations of those words which have been identified in the literature and relate to the concept under analysis.

There is a significant connection between the meaning of the concept and its context.[29] From an ontological perspective, this contextualization results in a change of conceptual meaning each time the context changes, and this informed the choice of concept for this paper; the term *engagement* has several meanings, but even when adopting a similar meaning, there are many different interpretations dependent upon the context, such as work engagement or user engagement (referring to engagement in technology). It has therefore been important to clearly specify the context of the engagement for this analysis; in this case, a focus on CPD engagement in the context of AHPs and Nurses/Midwives in a health or care setting.

Risjord[29 (p690)] determined that "the development of a concept requires a commitment to Moderate Realism" or "common sense approach." In contrast, Duncan et al[26] propose that contextualism necessitates a relativist context-bound ontology wherein concepts, despite an element of subjectivity, are constrained by the context in which they exist. In this instance, CPD engagement will in part be governed by regulatory bodies such as the Health and Care Professions Council (HCPC) or Nursing and Midwifery Council (NMC) in UK health and social care environments. Nuopponen,[32] in her exploration of the literature pertaining to concept analyses, concluded that designing a flaw-resistant process for undertaking a concept analysis was impossible because of its complexity. CPD engagement is a relatively new concept for which the defining attributes agreed upon in the UK today could change over time as regulations and the practice settings alter. Hence an ontology of moderate realism has been adopted in which the current UK context is acknowledged throughout.[29]

To facilitate the analysis, an initial search was undertaken in health and social care, education, business, and consumer databases to include OVID, PubMed, CINAHL, PsychINFO, ERIC, and ABI INFORM. Search terms included *engagement*, *work engagement*, *user engagement*, *consumer engagement* and *scholarship/school engagement*, *continuing professional development*, *continuing professional education*, and *life-long learning* from 1995 to 2017. Once the core definitions of engagement and CPD were confirmed, a more specific search within the AHPs and Nursing and Midwifery was undertaken to acknowledge context. Inclusion and methodological quality of the literature retrieved was independently assessed, then later discussed and agreed by the authors. Articles included definition of CPD and excludes those pertaining to CPD outcomes.

In stage 1, engagement was selected as the concept to be analyzed, and in stage 2, the purpose of the analysis was to determine the attributes of engagement so that its impact could be measured.

CPD Engagement: Definitions, Key Characteristics, and Attributes (Stages 3 and 4)

A considerable volume of literature attempts to operationalize the concept of engagement, most of which is contextualized, such as that relating to work, school, consumers, or user engagement (technology). Although some authors[29,33] suggest that consideration of context is significant in the formulation of a concept analysis, Walker and Avant[20] stress the importance of exploring the core concept (i.e., engagement) from a range of perspectives while still narrowing the context in terms

of context for the purpose of intention (i.e., CPD engagement for AHPs and Nurses/Midwives).

Engagement: Attitudinal or Behavioral?

Engagement is considered to involve cognition,[34] behavior,[35,36] interaction,[37] and motivation,[38] specifically intrinsic.[39,40] In relation to work, Bakker[41] described engagement as the desire to devote time to something, and he stressed the need to separate the concept of work engagement (in terms of the emotive or dedication) from job satisfaction, which is an attitude toward the work.

Bargagliotti[42] explored the concept of work engagement, as did Schaufeli and Bakker,[43] who highlighted that it was a "positive, fulfilling state of mind about work that is characterized by vigor, dedication and absorption."*43*(p295). This notion of absorption appears to be described in several papers as *flow*, which, although Schaufeli and Bakker[43] state is a more complex concept, can be described as focused, effortless attention and intrinsic enjoyment.

The individual's perceived control and choice is critical when clarifying the concept of engagement, as the higher the perceived choice, the higher the engagement.[40,44] There is a clear conflict here between the mandatory requirement for CPD by the UK regulatory bodies[2,18] and the belief that CPD should be self-initiated/voluntary.[17] Although CPD in UK for health and care professionals is mandatory, the HCPC and NMC have outlined a wide range of activities that could be considered to facilitate CPD.[2,18] This range of activities offers individuals greater choice than required

attendance at a number of accredited courses providing mandatory CPD points. Individuals also have a choice about if and how they apply the new learning and to what extent they continue to develop their skills in any area. This element of choice therefore seems integral to engagement in CPD and aligns well with self-determination theory, in which the elements of choice and cognitive engagement are identified as inter-related[45].

Engagement as Attitudinal and Behavioral

Although, as shown above, engagement can be identified by either attitudinal (high motivational state) or behavioral (high levels of activity, initiative, and responsibility) perspectives, the concept of employee engagement could be effectively defined by both.[46]

Several authors have suggested that engagement requires attention and intrinsic interest[44,47] alongside high cognitive and physical energy,[41,48] as well as the perception of engagement in learning being purposeful.[49] Supporting this, Kahn[50] suggests clarification of the notion of personal engagement by emphasizing the need for the individual to be physically engaged, cognitively aware, and connected emotionally. This emotional connectedness aligns to the idea of dedication, highlighted earlier,[31] which comprises a sense of significance, challenge, pride, and enthusiasm, alongside absorption, concerning the act of being engrossed in ones work. Literature relating to CPD refers to this as the ideal expected from professionals who should have an internal desire to “engage” in CPD and strive toward the highest quality of care for their patients/service users.[2,7,51,52] However, acknowledgment of the importance of negative factors such as increasing workload and lack of resources goes some way to explaining why this is not always the case.

These factors are explored further when considering the antecedents for CPD engagement, which are detailed later in this paper.

This idea that a combination of attitudinal and behavioral factors contributes to engagement was supported by Wellins and Concelman,[53(p1)] who state it was “an amalgamation of commitment, loyalty, productivity and ownership.” This idea can be usefully applied to assisting clarification of the concept of CPD engagement where

1) *commitment* applies to the desire to deliver the highest quality of care and dedication to the CPD activity;
2) *loyalty* relates to patients/service users in our care and to the profession to which we belong;
3) *productivity* highlights the time and effort afforded to applying, recording, and evaluating the CPD; and
4) *ownership* refers to self-selection of activity and acknowledgment of professional responsibility toward CPD.

The four factors outlined above suggest a link between the responsibilities and values of professionals and engagement in CPD, especially within the health and care professions such as nursing and AHPs. In this health and care context, motivation to deliver a service to others and the drive for excellence were identified as intrinsic motivating factors by the Allied Health Professions Project,[7] whose definition of CPD informed the regulatory body CPD requirements for the allied health professionals in the UK. Within the UK, O’Sullivan[54] highlighted that to engage in CPD, the health and social care professional learner must be responsible for identifying and planning their own learning needs to ensure an ongoing process of analysis, activity and evaluation. This self-directedness is based on andragogical

principles[55,56] in which adult learners are internally motivated, self-directed, and relevancy orientated, requiring meaningfulness to ensure engagement with those things undertaken. The benefits model, in which CPD is voluntary, self-monitored, and undertaken to increase knowledge and skills,[57] reflects and links well with andragogical principles and, as a result, can help to define concept of CPD engagement.

The majority of attitudinal and behavioral attributes of the concept of CPD engagement derived from the literature and described above have arisen from exploring the positive aspects of engagement such as motivation, self-directedness, and the rewards of engaging in CPD. It can, however, also be useful to explore the opposites of a concept.[20] This is encouraged by Walker and Avant[20] in their model wherein they suggest that exploring the defining characteristics of the concept's opposite can often help confirm the nature of the actual concept of investigation. Within literature exploring work engagement, the opposite is considered to be *burnout*, and much of the literature accessed for the purpose of this concept analysis considers reasons for burnout rather than purely examining the nature of engagement.[43,58-60] Burnout comprises emotional exhaustion and cynicism,[48] attributes that are reflected in the contrary case (see constructed cases presented later), and are often evident when there is a lack of engagement in CPD; although individuals might recognize the importance of engaging in CPD, high workloads together with a lack of resources and support from the organization provide an excuse for lack of CPD engagement and support the subsequent cynicism.[43,61] In relation to CPD, the term dis-engagement as the opposite may appear to be more appropriate, but in the context of health and social care, this concept of burnout may

well accurately represent a person who has become disengaged with their profession and sees no reason to develop professionally any further.

Within all the attributes considered so far, two core themes emerge.[53] The first refers to *attitudinal engagement*[31,43,62] and the second refers to *behavioral engagement*.[2, 35,36,44,52] The majority of CPD literature suggests that the most important outcome of CPD is the impact on quality of patient care,[2,7,52,63,64] which, although it is considered to be behavioral, is positively influenced by attitudes. This therefore suggests that both attitudinal and behavioral attributes are inextricably linked. When deciding upon the defining attributes of CPD engagement for health and care professionals, patient quality must be at the core, and hence clarification using both dimensions was considered essential, reflecting the process of concept contextualization.[29]

Once meaning is established within a concept analysis, Walker and Avant[1] highlight that it is important to untangle the antecedents, defining attributes, and consequences, as these have often been confused.[42,61] This allows clear criteria to emerge for the purpose of research. This process is illustrated below.

Defining Attributes (Stage 4)

Defining attributes are defined as those characteristics that can not only define but also differentiate the concept.[20] Chinn and Kramer[33(p88)] state, “for the expression of both qualitative and quantitative meaning of a concept…as you develop criteria you will naturally refine them so that they reflect the meaning they intend.”

With full consideration of the attributes and analysis of the emerging themes from the literature presented, five defining attributes of CPD engagement for nurses, midwives, and AHPs have been developed as follows. CPD engagement is confirmed when

1) The activity is *self-initiated* and undertaken *voluntarily* rather than as a result of a mandatory requirement.

2) The individual feels *rewarded* either intrinsically (e.g., enjoyment) or extrinsically (e.g., promotion) during or after undertaking the CPD activity.

3) The knowledge/skills gained via CPD are embraced and *applied* in practice for the benefit of the service/service user.

4) Learning is *recorded*, *evaluated*, and *shared* with others.

5) Learning is evidenced to *continue beyond* the initial CPD activity.

These defining attributes are now illustrated in the constructed cases below.

Constructed Cases (Stages 5 and 6)

Figures 1-4 provide constructed cases to illustrate where CPD engagement is either present in its entirety according to the five defining attributes proposed above (Figure 1) or has no elements (Figure 2) or some elements only (Figures 3 and 4) of engagement.

*Figure 1 Model Case: example **reflecting all** defining attributes*
Susan is a Band 7 Lead Occupational Therapist on a Stroke unit. She was delighted this month to read an article in the British Journal of Occupational

Therapists about Constraint-Induced Movement Therapy as a new technique for encouraging a return to function for stroke survivors. She uses the internet to explore further evidence of this approach and contacts the authors, who agree for Sally to spend a few days with them observing and learning how to apply the approach in practice. She prepares a case to negotiate the time off in supervision. Following her experience, she makes detailed notes, reflecting on her experience, and on her return to work she highlights four patients to trial the new approach, taking a baseline measurement of ability before she begins the treatment and re-measuring four weeks later. Excited by the results, she documents a report for the clinical director and prepares an in-service training session for the team and a skill development session for the local neurology special interest group. She uses the TRAMm Model (see later) to guide the documentation of her activity on a TRAMm Tracker, providing more detail on a TRAMm Trail,[52] which she files in her portfolio alongside her reflection and report, as she is aware this will provide useful evidence if she is called for audit by the HCPC.

316

*Figure 2: Contrary Case: example reflecting **no** defining attributes.*

Joe, a band 6 Physiotherapist, attends supervision because it is compulsory within his workplace. His supervisor reminds him that he has not evidenced any notable CPD in the last year, and as an HCPC registered professional it is his responsibility. To “keep his supervisor off his back” he locates a one-day free course on a new Act that some of his colleagues are attending. During the course, he listens to the introduction before spending the rest of the day making a list of all the things he needs to sort for his holiday in a few weeks, investigating the best

surfing beaches on his iPad. At the end of the day, he collects his certificate and puts it in his drawer to show to his supervisor the next time they meet.

317

*Figure 3 Related Case: has **many but not all** attributes.*

Sue, a Band 8a nurse, wishes to move from her current post in mental health, where she has been for the last five years, to a new role in education. She is coming to the end of her Master's degree, which she is taking because she knows it will help her in securing a job within the University sector. With the support of time and full funding from her organization, Sue has enjoyed studying again and is proud of her high grade average. She has been a student mentor within the workplace and has developed new student mentorship strategies following a project undertaken during her recent studies. Until recently, Sue was doing some sessional teaching, although this stopped when she was informed by her manager that she had to take leave as she was being paid.

This case is related; criteria 1, 2, and 3 are met/partly met, although motivation for being a sessional speaker is questionable since payment stopped. In relation to criteria 4, there is no evidence of recording or evaluating CPD with the exception of assignments. Learning beyond CPD activity (5) is not explicit.

318

Figure 4 Borderline Case: the distinction as to whether it represents CPD engagement is unclear.

Jackie is a Band 5 Dietician who is two years into her first post in oncology at a busy teaching hospital. She has undertaken a couple of one-day update courses regarding nutrition for patients with a Percutaneous Endoscopic Gastrostomy (PEG) feed and undertakes a reflection following each one. She also attends an inter-professional journal club that is held on the unit every two months and that includes a CPD feedback session and presentation prior to the journal discussion. Next week it is Jackie's turn to present on the role of the Dietician with people who are PEG fed prior to discussing the article, so she is preparing the information and has checked the internet to make sure she has the most up-to-date information. She places a copy of this presentation alongside her course reflections in her portfolio.

This case appears to meet the defining attributes. The unclear elements are the levels of autonomy in terms of choice of CPD and degree of application in practice. The courses do relate to her work on the unit so choice and application could be assumed. There is also little indication of drive/motivation and reward, but again, this could be implicit, as she strives to make sure her information is current, suggesting pride in her work.

Antecedents and Consequences of CPD Engagement (Stage 7)

One of the first antecedents of CPD, which is considered to be an element of professionalism, is the desire to know more.[42,65] For an individual to engage in CPD, it is suggested that they must show readiness to be a self-directed learner.[66] This readiness is influenced by "beliefs or attitudes to learning, the degree of

metacognitive awareness of themselves as learners, and personal definitions of competence to practice, with experience in supervision…and years employed."[66(p1)]

Kim et al[60] support this, noting the positive correlation of conscientiousness of the individual in relation to work engagement. The HCPC and Allied Health Professions Project[3,8] further highlighted how work engagement can be positively related to CPD engagement within the health and care professionals, in particular from positive drivers such as the desire to provide a high-quality service to patients/service users.

Although the importance of the individual characteristics for CPD engagement such as a desire to know more and provide a high-quality service has been emphasized,[3,8,60,66] it could be argued that these characteristics are not the most significant factors.[61,66] Resources are identified as especially important in encouraging work engagement, and as CPD is usually undertaken in the workplace, these factors are inextricably linked.[61] Several authors agree that availability of resources is critical for CPD engagement,[43,67-69] and this appears to be supported by anecdotal evidence from managers and practitioners. The authors suggest that resources for CPD (to include money and time) are now made less readily available by organizations, and this access limitation has resulted in a lack of engagement in CPD.[1,8]

In addition to sufficient resources, there must be a clear activity that is identifiable as CPD so that engagement occurs, but as the HCPC[2] identifies, this can be from a wide range of options as long as it can be clearly separated from what is considered to be normal work practice. However, with increasing workloads, guilt associated

with taking time out from what is seen as critical patient care also causes people to disengage from CPD.[51,54] In contrast, organizations considered to be learning organizations[54] facilitate CPD engagement by their employees; individuals are afforded opportunities to identify and address learning needs that may or may not be explicitly acknowledged. Learning organizations encourage pursuit of evidence-based practice and processes such as appraisal, supervision, mentorship, and preceptorship that help to facilitate and nurture a supportive environment.

Work engagement literature[61,62,67-69] also suggests that the level of value or purpose placed on learning could in itself be an antecedent to CPD engagement.[49] Engagement in the job is more likely to stimulate the drive to know more so that quality of work can continue to grow. Similarly, the opposite may be the case, where burnout in an existing role can lead to an extrinsic desire for CPD to facilitate a change in career direction.

When examining the *consequences*, effective CPD, in which individuals are fully engaged, is thought to be positively associated with an increased quality of care. [1,2,7,52,63] If the defining attributes of CPD engagement are extant, then service users should benefit from CPD undertaken by individuals who are driven by the need to know more and discover the evidence for their practice. Many authors indicate that work engagement is positively associated with greater job satisfaction and less chance of burnout.[43,48,58-60] They also suggest that if someone is engaged in work, they have a drive to know more and strive for best practice, which is furthered by engagement in CPD. Hence, it should follow that CPD engagement results in greater learner satisfaction and job satisfaction and, therefore, greater staff retention.[1,54,70-72]

Finally, full CPD engagement should lead to greater knowledge and wider dissemination of learning,[1] and hence there is the potential for the learning to benefit a greater range of stakeholders at either local, national, or international levels.

Empirical Referents (Stage 8)

Empirical referents are those tools designed to demonstrate ways in which the concept (in this case, CPD engagement for nurses and allied health professionals) can be more effectively understood and measured.[20] This section therefore identifies some examples of the way in which the measurement of CPD engagement can be captured.

The literature indicated a lack of clearly defined measurement tools to ascertain the success of engagement in CPD and acknowledges the lack of effective evaluation tools, citing the complexity of the concept.[5] This suggests that much of CPD is evaluated via satisfaction surveys or tools designed as bespoke (non-standardized) for each study undertaken.[1,4,10,52]

In addition to the General Medical Council and the NMC, the HCPC is one of the core regulatory bodies in the UK for health and care professions. They outline five standards against which registrants should show evidence of successful engagement in CPD.[2] Measurement is mapped against the criteria of undertaking a range of activities that are then applied in practice for the benefit of the service user. Registrants are audited biennially and may be called to provide further evidence.[3] The limitations of this process involve the lack of sensitivity of the audit process

around CPD engagement, as only 2.5% of registrants are selected every two years. For those 2.5% who are selected, anecdotal evidence suggests a sudden flurry of activity to gather and provide the information required for audit, rather than engagement in the recording and evaluative process throughout the working life of the individual.

One CPD model, based around a benefit model, has been designed to try to redress the balance promoting CPD engagement rather than output and sanction models in which CPD is undertaken purely as part of regulation.[57] To try to encourage UK allied health and care professionals to engage in and measure the impact of their CPD, The TRAMm (Tell, Record, Apply, Monitor, measure) Model[52,64] was designed. Within this model, the need to measure the link between CPD and outcome of practice is emphasized, and a variety of ways that the outcomes of CPD can be measured are indicated within the available resources. The TRAMm Model identifies a set of core components (stations) AHPs should address to demonstrate that they are actively engaging in CPD; its accompanying TRAMm Trail and Tracker are tools provided to help monitor and measure progress. The TRAMm Tracker and Trail[52] have the potential to provide detailed evidence of CPD engagement alongside reflections and other written documentation. As relatively new tools, they have been evaluated as part of a small pilot study but are yet to be comprehensively investigated as part of a full research study. Anecdotal evidence suggests that TRAMmCPD has helped to facilitate a greater understanding and recording of CPD engagement together with monitoring and measurement of the application, but it is acknowledged that further evaluation is required.[52]

To assist the measurement of CPD, standardized outcome measures could be used to evaluate the impact of improved/new interventions on service users undertaken as a result of CPD. It is, however, problematic and imprudent to make a direct link between CPD and the outcome[10] and even more challenging to show any relationship to CPD engagement. The most effective ways to demonstrate CPD engagement are therefore currently considered to be through supervision or annual appraisal/preceptorship programs in which individual goals for health and care professionals such as nurses and allied health professionals can more easily be negotiated, monitored, and measured.

Conclusion

Reference to CPD engagement is becoming more commonplace, particularly for AHPs and Nurses/Midwives, but the concept is complex, and problems with clarification result in difficulty in measuring its success in terms of impact. This concept analysis followed Walker and Avant's[20] framework, and a range of definitions of engagement were explored. Five defining attributes were identified: activity initiated by the individual and undertaken voluntarily; a reward; the application of knowledge and/or skills for the benefit of the service user; learning that is recorded, evaluated, and shared with others; and continuation of learning beyond the initial CPD activity. There is clear conflict between the fact that CPD for AHPs and Nurses/Midwives itself is mandatory, whereas CPD engagement is considered to be voluntary and self-initiated. There may be instances in which individuals may initially undertake CPD for reasons that are originally considered to be involuntary, but CPD *engagement* can ensue which cannot be forced and can only occur on a voluntary basis. There are other concepts that may, in the future, add to this

analysis, such as those of self-directed and self-regulatory learning, which underpin the core defined attributes. It is, however anticipated that the defining attributes presented in this concept analysis may now be used and tested to further the research and greater accuracy of measurement of the impact of CPD engagement.

Lessons for Practice

- Concept analyses are useful in the clarification of the meaning of complex concepts.

- There are five defining attributes of CPD Engagement for AHPs and Nurses/Midwives.

- The five attributes are engagement is voluntary or self-initiated, there is a reward (intrinsic/extrinsic), learning is applied for the benefit of the service user/patient, learning is recorded evaluated and shared with others, and learning continues beyond the initial CPD activity.

- The defining attributes could be used to enable measurement of CPD engagement and facilitate measurement of impact.

- Antecedents and consequences of CPD engagement highlighted can usefully inform organizations of the value in supporting CPD.

References

1. Academy of Medical Royal Colleges (AMRC) *The Effectiveness of Continuing Professional Development (Final Report)* 2010. London: General Medical Council.

2. Health and Care Professions Council (HCPC) *Continuing Professional Development and Your Registration*. 2017. London: Health and Care Professions Council.

3. Donyai P, Alexander A, Denicolo P. A Framework for Assessing Continuing Professional Development Activities for Satisfying Pharmacy Revalidation Requirements. *J Contin Educ Health Prof.* 2008;33(2):127-135.

4. Ikenwilo D, Skåtun D. Perceived Need and Barriers to Continuing Professional Development among Doctors. *Health Policy Educ.* 2014;117(2):195-202.

5. Friedman A, Davis K, Phillips M. *Continuing professional development in the UK: Attitudes and experiences of practitioners.* Bristol: Professional Associations Research Network; 2001.

6. Phillips M, Doheny S, Hearn C. *The Impact of Continuing Professional Development.* Bristol: University of Bristol; 2004.

7. Allied Health Professions Project (AHPP) *Demonstrating competence through CPD*. 2003. London: Department of Health.

8. Gould D, Berridge E, Kelly D. The National Health Service Knowledge and Skills Framework and its implications for continuing professional development in nursing. *Nurse Education Today* 2006;27:26–34.

9. Gusky T. Staff development and the process of teacher change. *Educational Researcher.* 1986;15(5):5-12.

10. Chipchase L, Johnston V, Long P. Continuing Professional Development: The Missing Link. *Man Ther.* 2012;17:89-91.

11. Eaton K, Brooks J, Patel R, Batchelor P, Merali F, Narain A. *The Impact of Continuing Professional Development in Dentistry: A Literature Review.* London: General Dental Council; 2011.

12. Schostak J, Davis M, Hanson J, et al. *The effectiveness of Continuing Professional Development: Final Report.* London: College of Emergency Medicine; 2010.

13. Cervero R, Gaines J. The Impact of CME on Physician Performance and Patient Health Outcomes: An Updated Synthesis of systematic Reviews *J Contin Educ Health Prof.* 2015;35(2):131 - 138.

14. Higgs J. Physiotherapy, Professionalism and Self-directed Learning. *Journal of Singapore Physiotherapy Association.* 1993;14(1):8-11.

15. Bossers A, Kernaghan J, Hodgins L. Defining and developing professionalism. *Canadian Journal of Occupational Therapy.* 1999;66(3):116-121.

16. Haines P. Professionalization through CPD: is it realistic for achieving our goals? *British Journal of Therapy and Rehabilitation.* 1997;4(8):428-447.

17. Ryan J. Continuous professional development along the continuum of lifelong learning. *Nurse Educ Today.* 2003;23:498–508.

18. Nursing and Midwifery Council (NMC). NMC. How to Revalidate with the NMC. Requirements for Renewing your Registration. https://www.nmc.org.uk/globalassets/sitedocuments/revalidation/how-to-revalidate-booklet.pdf Accessed 28/04/18.

19. Botes A. Concept Analysis: Some limitations and possible solutions. *Curationonis: Journal of the Democratic Nursing Organisation of South Africa.* 2002;25(3):23-27.

20. Walker L, Avant K, Walker E. *Strategies for theory construction in nursing.* 5 ed. Boston: Prentice Hall; 2010.

21. Nuopponen A. Methods of Concept Analysis (Part 1); a comparative study. *LSP Journal.* 2010;1(1):4-12.

22. Royal College of Nursing (RCN) *A joint statement on continuing professional development for health and social care practitioners*. 2007. London: Royal College of Nursing.

23. Broughton W, Harris G. *Principles for Continuing Professional Development and Lifelong Learning in Health and Social Care.* Bridgwater: College of Paramedics; 2019.

24. Beckwith S, Dickenson A, Kendall S. The “con” of concept analysis A discussion paper which explores and critiques the ontological focus, reliability and antecedents of concept analysis frameworks. *Int J Nurs Stud.* 2008;45:1831–1841.

25. Baldwin M. Concept Analysis as a Dissertation Methodology. *Nurse Educ Today.* 2009:780 - 783.

26. Duncan C, Cloutier J, Bailey P. Concept analysis: the importance of differentiating the ontological focus. *J Adv Nurs.* 2007;58:293 - 300.

27. Wilson J. *Thinking with concepts* Cambridge: Cambridge University Press; 1963.

548 28. Morse J. Exploring the theoretical basis of nursing knowledge using advanced
549 techniques of concept analysis. *Advances in Nursing Science.* 1995;17:31 -
550 46.
551 29. Risjord M. Rethinking Concept Analysis. *J Adv Nurs.* 2009;65(3):684 - 691.
552 30. Yazdani S, Hosseini F, Ahmady S. System based practice: a concept
553 analysis. *Journal of Advances in Medical Education and Professionalism.*
554 2016;4(2):45-53.
555 31. Bakker A, Schaufeli W, Leiter M, Taris T. Position paper. Work engagement:
556 an emerging concept in occupational health psychology. *Work Stress.*
557 2008;22(3):187 - 200.
558 32. Nuopponen A. Methods of Concept Analysis (Part 2); Towards Systematic
559 Concept Analysis. *LSP Journal.* 2010;1(2):5-14.
560 33. Chinn P, Kramer M. *Theory and nursing: a systematic approach.* London:
561 Mosby; 1995.
562 34. Laurel B. *Computers as Theatre.* Reading MA: Addison-Wesley; 1993.
563 35. Kappelman L. Measuring user involvement: A diffusion of innovation
564 perspective. *Database Advances.* 1995;26(2/3):65-86.
565 36. Hutchins E, Holland J, Norman D. Direct manipulation interfaces. In: D
566 Norman, S Draper, eds. *User centered system design: New perspectives on*
567 *human-computer interaction.* Mahwah, NJ: Lawrence Erlbaum Associates;
568 1986.
569 37. Quesenbery W. Dimensions of usability. In: M Albers, B Mazur, eds. *Content*
570 *and complexity: Information design in technical communications.* Mahwah,
571 NJ: Lawrence Erlbaum Associates; 2003.

572 38. Makkonen P. Does collaborative hypertext support better engagement in
573 learning the basics of informatics? *SIGCSE Bulletin.* 1997;29(3):130-132.
574 39. Jacques R. The nature of engagement and its role in hypermedia evaluation
575 and design [Unpublished doctoral dissertation]. In. London: South Bank
576 University; 1996.
577 40. Jacques R, Preece J, Carey T. Engagement as a design concept for
578 multimedia. *Canadian Journal of Educational Communication* 1995;24(1):49-
579 59.
580 41. Bakker A. Daily fluctuations in work engagement: An Overview and Current
581 Directions. *Eur Psychol.* 2014;19(4):227-236.
582 42. Bargagliotti A. Work engagement in nursing: a concept analysis. *J Adv Nurs.*
583 2012;68(6):1414-1428.
584 43. Schaufeli W, Bakker A. Job demands, job resources, and their relationship
585 with burnout and engagement: a multi-sample study. *Journal of*
586 *Organizational Behavior.* 2004;25:293-315.
587 44. Webster J, Ho H. Audience engagement in multimedia presentations. *The*
588 *DATA BASE for Advances in Information Systems.* 1997;28(2):63-77.
589 45. Ryan R, Deci E. Self-determination theory and the facilitation of intrinsic
590 motivation, social development and well-being. *Am Psychol.* 2000;55:68-78.
591 46. Macey W, Schneider B. The Meaning of Employee Engagement. *Industrial*
592 *and Organisational Psychology.* 2008;1:3-30.
593 47. Chapman P. Models of Engagement: Intrinsically Motivated Interaction with
594 Multimedia Learning Software [Unpublished master's thesis] In. Ontario,
595 Canada: University of Waterloo; 1997.

48. Maslach C, Schaufeli W, Leiter M. Job burnout. *Annu Rev Psychol.* 2001;52:397-422.

49. Kuh GD. What We're Learning About Student Engagement From NSSE: Benchmarks for Effective Educational Practices. *Change: The Magazine of Higher Learning.* 2003;35(2):24-32.

50. Kahn A. Psychological Conditions of Personal Engagement and Disengagement at Work. *The Academy of Management Journal.* 1990;33(4):692-724.

51. O'Sullivan J. Unlocking the Workforce Potential: is support for effective continuing professional development the key? . *Research in Post-Compulsory Education.* 2003;8(1):107-122.

52. Hearle D, Lawson S, Morris R. *A Strategic Guide to Continuing Professional Development for Health and Care Professionals: The TRAMm Model.* Keswick: M&K Publishing; 2016.

53. Wellins R, Concelman J. Creating a culture for engagement. *Workforce Performance Solutions.* 2005;4:1-4.

54. O'Sullivan J. Continuing Professional Development. In: R Jones, F Jenkins, eds. *Developing the Allied Health Professional.* Oxford: Radcliffe Publishing; 2006:1-16.

55. Knowles M. *Andragogy in action: Applying modern principles of adult education* San Francisco: Jossey-Bass; 1984.

56. Knowles M. *The modern practice of adult education: From pedagogy to andragogy.* Englewood Cliffs: Prentice Hall/Cambridge; 1980.

57. Madden C, Mitchell V. *Professions, Standards and Competence: a survey of continuing education for the health professions.* Bristol: University of Bristol; 1993.

58. Van den Broeck A, Vansteenkiste M, DeWitte H, Lens W. Explaining the relationships between job characteristics, burnout and engagement. *Work Stress.* 2008;22(3):277-294.

59. Van den Broeck A, De Cuyper N, De Witte H, Vansteenkiste M. Not all job demands are equal: Differentiating job hindrances and job challenges in the Job Demands-Resources model. *European Journal of Work and Organizational Psychology.* 2010;19(6):735-759.

60. Kim H, Shin K, Swanger N. Burnout and engagement: a comparative analysis of the big five personality dimensions. *International Journal of Hospitality Management.* 2009;28:96-104.

61. Simpson M. Engagement at Work: A Review of the Literature. *Int J Nurs Stud.* 2009;46(7):1012-1024.

62. Bakker A, Demerouti E. Towards a model of work engagement. *Career Development International.* 2008;13(3):209-223.

63. HM Government. H.M. Government. Our healthier nation A contract for health 1998; https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265721/title.pdf. Accessed 15/03/2016

64. Lawson S. Occupational Therapists understanding of and engagement in Continuing Professional Development. Royal College of Occupational Therapists Annual Conference and Exhibition 2018; Belfast.

643 65. Haywood H, Pain H, Ryan S, Adams J. Engagement with Continuing
644 Professional Development: Development of a Service Model. *J Allied Health.*
645 2012;41(2):83-89.
646 66. Penman M. *Do we have what it takes? An investigation into New Zealand*
647 *occupational therapists' readiness to be self-directed learners.* New Zealand,
648 University of Otago, New Zealand; 2014.
649 67. Koyuncu M, Burke R, Fiksenbaum L. Work engagement among women
650 managers and professionals in a Turkish bank: potential antecedents and
651 consequences *Equal Opportunities International.* 2006;25:299-310.
652 68. Hakanen J, Perhonieumi R, Toppinen-Tanner S. Positive gain spirals at work:
653 from job resource to work engagement, personal initiative and work-unit
654 innovativeness. *J Vocat Behav.* 2008;73(1):78-91.
655 69. Hakanen J, Schaufeli W, Ahola K. The job demands resources model: a
656 three-year cross-lagged study of burnout, depression, commitment, and work
657 engagement. *Work Stress.* 2008;22(3):224-241.
658 70. Mauno S, Kinnunen U, Ruokolainen M. Job demands and resources as
659 antecedents of work engagement: A Longitudinal Study. *J Vocat Behav.*
660 2007;70:149-171.
661 71. Cho J, Laschinger H, Wong C. Workplace Empowerment, Work Engagement
662 and Organisational Commitment of New Graduate Nurses. *Nurs Leadersh.*
663 2006;19(3):43-60.
664 72. Shuck B, Ghosh R, Zigarmi D, Nimon K. The Jingle Jangle of Employee
665 Engagement: Further Exploration of the Emerging Construct and Implications
666 for Workplace Learning and Performance. *Human Resource Development*
667 *Review.* 2013;12:11.

668