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

2 Concept Analysis

3

4

5 Abstract

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

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

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

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

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

30

31 **Introduction and Background**

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

37

38 The importance of CPD was highlighted by Guskey in 1986,⁹ who stated that high-
39 quality staff development was thought to be the most important factor in the
40 improvement of education. In recent years, much of the literature pertaining to health
41 and care suggests that although people believe CPD to be essential and effective in
42 driving quality of care,^{7,8} there is little measurement of its effectiveness on patient
43 outcome for the allied health professions (AHP) and Nursing and Midwifery^{1,10,11}

44 Several studies have, however, been undertaken in dentistry¹² and medicine, most
45 notably a systematic review by Cervero and Gaines¹³ that demonstrated positive
46 links between continuing education and physician performance and, to a lesser
47 extent, patient outcomes. They did, however, stipulate the presence of several
48 conditions for this to occur, including the need for multiple and longer exposures to
49 CPD and a focus on outcomes considered important by the physician. Although this

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

52

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

63

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

70

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

74 groups have been selected because they jointly formulated their guidance for CPD in
75 the UK in 2007²² which was collaboratively re-written this year.²³

76

77 **Concept Analysis Methodology**

78 Within health and care, concept analyses are increasing in popularity,^{24,25} and many
79 authors have highlighted their importance in helping to develop clarity of
80 understanding of concepts and theoretical frameworks.^{20,26-28} At this point it is
81 important to acknowledge that despite the acceptance of concept analyses, not all
82 value them as a valid and reliable tool for the purpose of developing operationalized
83 definitions for research.²⁹ This is due to the perceived lack of empirical research and
84 systematic searches involved. This criticism informed the choice of Walker and
85 Avant's²⁰ eight stage model for this concept analysis, which is acknowledged to
86 provide a more systematic approach to developing an understanding of concepts,
87 specifically in nursing and health care,³⁰ and has proved a useful mechanism to
88 explore and clarify the meaning of CPD engagement within this health care context.

89

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

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

99 7) Identify antecedents and consequences

100 8) Define empirical referents

101

102 Walker and Avant's²⁰ model highlights the need to explore *positive psychology*,³¹
103 referring to the need to develop a greater understanding of the nature, antecedents,
104 and consequences of CPD engagement rather than purely exploring why people do
105 not engage. This helps to promote an understanding of the concept in greater depth
106 by identifying all factors that contribute to CPD engagement.

107

108 There are two main types of concept analysis, theoretical and colloquial.²⁹ Within this
109 article, *theoretical*²⁹ concept analysis (defined through critique of the literature) has
110 been used for the clarification of the concept of CPD engagement, although the use
111 of some colloquial evidence is recognized, namely when the literature has uncovered
112 studies that have investigated perceptions of health professionals believed to be
113 engaging in CPD^{5,6}. Within a theoretical analysis, where a variety of disciplines (in
114 this case AHPs and Nursing and Midwifery) embrace the concept, evidence as to its
115 interpretation should be integrated accordingly while recognizing where context may
116 impact upon the way the concept is interpreted/used.²⁹ Derrida (1978 cited in
117 Beckwith)²⁴ stressed that it is also important to note that words may have two or
118 more meanings, and the meaning adopted may change the resulting analysis. For
119 example, the word *stress* can refer to a feeling of anxiety or the act of accentuating
120 something. Walker and Avant²⁰ therefore emphasize the need to investigate possible
121 interpretations of those words which have been identified in the literature and relate
122 to the concept under analysis.

123

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

133

134 Risjord²⁹ (p690) determined that “the development of a concept requires a commitment
135 to Moderate Realism” or “common sense approach.” In contrast, Duncan et al²⁶
136 propose that contextualism necessitates a relativist context-bound ontology wherein
137 concepts, despite an element of subjectivity, are constrained by the context in which
138 they exist. In this instance, CPD engagement will in part be governed by regulatory
139 bodies such as the Health and Care Professions Council (HCPC) or Nursing and
140 Midwifery Council (NMC) in UK health and social care environments. Nuopponen,³²
141 in her exploration of the literature pertaining to concept analyses, concluded that
142 designing a flaw-resistant process for undertaking a concept analysis was impossible
143 because of its complexity. CPD engagement is a relatively new concept for which the
144 defining attributes agreed upon in the UK today could change over time as
145 regulations and the practice settings alter. Hence an ontology of moderate realism
146 has been adopted in which the current UK context is acknowledged throughout.²⁹

147

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

159

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

163

164 **CPD Engagement: Definitions, Key Characteristics, and Attributes (Stages 3** 165 **and 4)**

166 A considerable volume of literature attempts to operationalize the concept of
167 engagement, most of which is contextualized, such as that relating to work, school,
168 consumers, or user engagement (technology). Although some authors^{29,33} suggest
169 that consideration of context is significant in the formulation of a concept analysis,
170 Walker and Avant²⁰ stress the importance of exploring the core concept (i.e.,
171 engagement) from a range of perspectives while still narrowing the context in terms

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

174

175 *Engagement: Attitudinal or Behavioral?*

176 Engagement is considered to involve cognition,³⁴ behavior,^{35,36} interaction,³⁷ and
177 motivation,³⁸ specifically intrinsic.^{39,40} In relation to work, Bakker⁴¹ described
178 engagement as the desire to devote time to something, and he stressed the need to
179 separate the concept of work engagement (in terms of the emotive or dedication)
180 from job satisfaction, which is an attitude toward the work.

181

182 Bargagliotti⁴² explored the concept of work engagement, as did Schaufeli and
183 Bakker,⁴³ who highlighted that it was a “positive, fulfilling state of mind about work
184 that is characterized by vigor, dedication and absorption.”^{43(p295)} This notion of
185 absorption appears to be described in several papers as *flow*, which, although
186 Schaufeli and Bakker⁴³ state is a more complex concept, can be described as
187 focused, effortless attention and intrinsic enjoyment.

188

189 The individual’s perceived control and choice is critical when clarifying the concept of
190 engagement, as the higher the perceived choice, the higher the engagement.^{40,44}

191 There is a clear conflict here between the mandatory requirement for CPD by the UK
192 regulatory bodies^{2,18} and the belief that CPD should be self-initiated/voluntary.¹⁷

193 Although CPD in UK for health and care professionals is mandatory, the HCPC and
194 NMC have outlined a wide range of activities that could be considered to facilitate
195 CPD.^{2,18} This range of activities offers individuals greater choice than required

196 attendance at a number of accredited courses providing mandatory CPD points.
197 Individuals also have a choice about if and how they apply the new learning and to
198 what extent they continue to develop their skills in any area. This element of choice
199 therefore seems integral to engagement in CPD and aligns well with self-
200 determination theory, in which the elements of choice and cognitive engagement are
201 identified as inter-related⁴⁵.

202 *Engagement as Attitudinal and Behavioral*

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

207

208 Several authors have suggested that engagement requires attention and intrinsic
209 interest^{44,47} alongside high cognitive and physical energy,^{41,48} as well as the
210 perception of engagement in learning being purposeful.⁴⁹ Supporting this, Kahn⁵⁰
211 suggests clarification of the notion of personal engagement by emphasizing the need
212 for the individual to be physically engaged, cognitively aware, and connected
213 emotionally. This emotional connectedness aligns to the idea of dedication,
214 highlighted earlier,³¹ which comprises a sense of significance, challenge, pride, and
215 enthusiasm, alongside absorption, concerning the act of being engrossed in ones
216 work. Literature relating to CPD refers to this as the ideal expected from
217 professionals who should have an internal desire to “engage” in CPD and strive
218 toward the highest quality of care for their patients/service users.^{2,7,51,52} However,
219 acknowledgment of the importance of negative factors such as increasing workload
220 and lack of resources goes some way to explaining why this is not always the case.

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

223

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

228 1) *commitment* applies to the desire to deliver the highest quality of care and
229 dedication to the CPD activity;

230 2) *loyalty* relates to patients/service users in our care and to the profession to
231 which we belong;

232 3) *productivity* highlights the time and effort afforded to applying, recording, and
233 evaluating the CPD; and

234 4) *ownership* refers to self-selection of activity and acknowledgment of
235 professional responsibility toward CPD.

236 The four factors outlined above suggest a link between the responsibilities and
237 values of professionals and engagement in CPD, especially within the health and
238 care professions such as nursing and AHPs. In this health and care context,
239 motivation to deliver a service to others and the drive for excellence were identified
240 as intrinsic motivating factors by the Allied Health Professions Project,⁷ whose
241 definition of CPD informed the regulatory body CPD requirements for the allied
242 health professionals in the UK. Within the UK, O’Sullivan⁵⁴ highlighted that to engage
243 in CPD, the health and social care professional learner must be responsible for
244 identifying and planning their own learning needs to ensure an ongoing process of
245 analysis, activity and evaluation. This self-directedness is based on andragogical

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

252

253 The majority of attitudinal and behavioral attributes of the concept of CPD
254 engagement derived from the literature and described above have arisen from
255 exploring the positive aspects of engagement such as motivation, self-directedness,
256 and the rewards of engaging in CPD. It can, however, also be useful to explore the
257 opposites of a concept.²⁰ This is encouraged by Walker and Avant²⁰ in their model
258 wherein they suggest that exploring the defining characteristics of the concept's
259 opposite can often help confirm the nature of the actual concept of investigation.
260 Within literature exploring work engagement, the opposite is considered to be
261 *burnout*, and much of the literature accessed for the purpose of this concept analysis
262 considers reasons for burnout rather than purely examining the nature of
263 engagement.^{43,58-60} Burnout comprises emotional exhaustion and cynicism,⁴⁸
264 attributes that are reflected in the contrary case (see constructed cases presented
265 later), and are often evident when there is a lack of engagement in CPD; although
266 individuals might recognize the importance of engaging in CPD, high workloads
267 together with a lack of resources and support from the organization provide an
268 excuse for lack of CPD engagement and support the subsequent cynicism.^{43,61} In
269 relation to CPD, the term dis-engagement as the opposite may appear to be more
270 appropriate, but in the context of health and social care, this concept of burnout may

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

273

274 Within all the attributes considered so far, two core themes emerge.⁵³ The first refers
275 to *attitudinal engagement*^{31,43,62} and the second refers to *behavioral engagement*.^{2,}
276 ^{35,36,44,52} The majority of CPD literature suggests that the most important outcome of
277 CPD is the impact on quality of patient care,^{2,7,52,63,64} which, although it is considered
278 to be behavioral, is positively influenced by attitudes. This therefore suggests that
279 both attitudinal and behavioral attributes are inextricably linked. When deciding upon
280 the defining attributes of CPD engagement for health and care professionals, patient
281 quality must be at the core, and hence clarification using both dimensions was
282 considered essential, reflecting the process of concept contextualization.²⁹

283

284 Once meaning is established within a concept analysis, Walker and Avant¹ highlight
285 that it is important to untangle the antecedents, defining attributes, and
286 consequences, as these have often been confused.^{42,61} This allows clear criteria to
287 emerge for the purpose of research. This process is illustrated below.

288

289 *Defining Attributes (Stage 4)*

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

294

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

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

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

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

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

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

307

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

309

310 *Constructed Cases (Stages 5 and 6)*

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

315

*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.

319

320

321 *Antecedents and Consequences of CPD Engagement (Stage 7)*

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

326 metacognitive awareness of themselves as learners, and personal definitions of
327 competence to practice, with experience in supervision...and years employed."^{66(p1)}

328

329 Kim et al⁶⁰ support this, noting the positive correlation of conscientiousness of the
330 individual in relation to work engagement. The HCPC and Allied Health Professions
331 Project^{3,8} further highlighted how work engagement can be positively related to CPD
332 engagement within the health and care professionals, in particular from positive
333 drivers such as the desire to provide a high-quality service to patients/service users.

334

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

346

347 In addition to sufficient resources, there must be a clear activity that is identifiable as
348 CPD so that engagement occurs, but as the HCPC² identifies, this can be from a
349 wide range of options as long as it can be clearly separated from what is considered
350 to be normal work practice. However, with increasing workloads, guilt associated

351 with taking time out from what is seen as critical patient care also causes people to
352 disengage from CPD.^{51,54} In contrast, organizations considered to be learning
353 organizations⁵⁴ facilitate CPD engagement by their employees; individuals are
354 afforded opportunities to identify and address learning needs that may or may not be
355 explicitly acknowledged. Learning organizations encourage pursuit of evidence-
356 based practice and processes such as appraisal, supervision, mentorship, and
357 preceptorship that help to facilitate and nurture a supportive environment.

358

359 Work engagement literature^{61,62,67-69} also suggests that the level of value or purpose
360 placed on learning could in itself be an antecedent to CPD engagement.⁴⁹

361 Engagement in the job is more likely to stimulate the drive to know more so that
362 quality of work can continue to grow. Similarly, the opposite may be the case, where
363 burnout in an existing role can lead to an extrinsic desire for CPD to facilitate a
364 change in career direction.

365

366 When examining the *consequences*, effective CPD, in which individuals are fully
367 engaged, is thought to be positively associated with an increased quality of care.

368 ^{1,2,7,52,63} If the defining attributes of CPD engagement are extant, then service users
369 should benefit from CPD undertaken by individuals who are driven by the need to
370 know more and discover the evidence for their practice. Many authors indicate that
371 work engagement is positively associated with greater job satisfaction and less
372 chance of burnout.^{43,48,58-60} They also suggest that if someone is engaged in work,
373 they have a drive to know more and strive for best practice, which is furthered by
374 engagement in CPD. Hence, it should follow that CPD engagement results in greater
375 learner satisfaction and job satisfaction and, therefore, greater staff retention.^{1,54,70-72}

376

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

380

381 *Empirical Referents (Stage 8)*

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

387

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

393

394 In addition to the General Medical Council and the NMC, the HCPC is one of the
395 core regulatory bodies in the UK for health and care professions. They outline five
396 standards against which registrants should show evidence of successful
397 engagement in CPD.² Measurement is mapped against the criteria of undertaking a
398 range of activities that are then applied in practice for the benefit of the service user.
399 Registrants are audited biennially and may be called to provide further evidence.³

400 The limitations of this process involve the lack of sensitivity of the audit process

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

406

407 One CPD model, based around a benefit model, has been designed to try to redress
408 the balance promoting CPD engagement rather than output and sanction models in
409 which CPD is undertaken purely as part of regulation.⁵⁷ To try to encourage UK allied
410 health and care professionals to engage in and measure the impact of their CPD,
411 The TRAMm (Tell, Record, Apply, Monitor, measure) Model^{52,64} was designed.
412 Within this model, the need to measure the link between CPD and outcome of
413 practice is emphasized, and a variety of ways that the outcomes of CPD can be
414 measured are indicated within the available resources. The TRAMm Model identifies
415 a set of core components (stations) AHPs should address to demonstrate that they
416 are actively engaging in CPD; its accompanying TRAMm Trail and Tracker are tools
417 provided to help monitor and measure progress. The TRAMm Tracker and Trail⁵²
418 have the potential to provide detailed evidence of CPD engagement alongside
419 reflections and other written documentation. As relatively new tools, they have been
420 evaluated as part of a small pilot study but are yet to be comprehensively
421 investigated as part of a full research study. Anecdotal evidence suggests that
422 TRAMmCPD has helped to facilitate a greater understanding and recording of CPD
423 engagement together with monitoring and measurement of the application, but it is
424 acknowledged that further evaluation is required.⁵²

425

426 To assist the measurement of CPD, standardized outcome measures could be used
427 to evaluate the impact of improved/new interventions on service users undertaken as
428 a result of CPD. It is, however, problematic and imprudent to make a direct link
429 between CPD and the outcome¹⁰ and even more challenging to show any
430 relationship to CPD engagement. The most effective ways to demonstrate CPD
431 engagement are therefore currently considered to be through supervision or annual
432 appraisal/preceptorship programs in which individual goals for health and care
433 professionals such as nurses and allied health professionals can more easily be
434 negotiated, monitored, and measured.

435

436 **Conclusion**

437 Reference to CPD engagement is becoming more commonplace, particularly for
438 AHPs and Nurses/Midwives, but the concept is complex, and problems with
439 clarification result in difficulty in measuring its success in terms of impact. This
440 concept analysis followed Walker and Avant's²⁰ framework, and a range of
441 definitions of engagement were explored. Five defining attributes were identified:
442 activity initiated by the individual and undertaken voluntarily; a reward; the
443 application of knowledge and/or skills for the benefit of the service user; learning that
444 is recorded, evaluated, and shared with others; and continuation of learning beyond
445 the initial CPD activity. There is clear conflict between the fact that CPD for AHPs
446 and Nurses/Midwives itself is mandatory, whereas CPD engagement is considered
447 to be voluntary and self-initiated. There may be instances in which individuals may
448 initially undertake CPD for reasons that are originally considered to be involuntary,
449 but CPD *engagement* can ensue which cannot be forced and can only occur on a
450 voluntary basis. There are other concepts that may, in the future, add to this

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

455

456 **Lessons for Practice**

457

458 • Concept analyses are useful in the clarification of the meaning of complex
459 concepts.

460

461 • There are five defining attributes of CPD Engagement for AHPs and
462 Nurses/Midwives.

463

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

468

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

471

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

474

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