Impact on practice (ImP) project: exploring the need for and utility of the ImP framework, final report to the East of England Strategic Health Authority

Other

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Impact on Practice (ImP) Project: Exploring the need for and utility of the ImP framework

October 2011
About the Impact on Practice (ImP) project

The ImP project is concerned with the impact of continuing professional development (CPD) on practice. The ImP framework was developed during Phase 1 of the project (2006–09).

This report focuses on Phase 2, undertaken during 2010–11, which explored the need for, and utility of, the ImP framework with a range of stakeholders in one of the County Workforce areas in East of England. Phase 2 was partly funded by the East of England Strategic Health Authority (SHA).

This report has been written by Liz Clark and Jan Draper, The Open University.
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Acknowledgements

First and foremost, we would like to thank all those who so generously agreed to participate in this project and share their ideas and experiences with enthusiasm during two rounds of interviews, often in their own time due to pressures at work in a period of significant uncertainty and upheaval. We encountered considerable passion for the importance of using learning in practice to benefit patients and service users and for making improvements to service delivery.

Particular thanks go to Dr Shelagh Sparrow, Project Officer, for carrying out all the interviews and undertaking the preliminary analysis of the data. Thanks are also due to Janie Barker for transcribing the taped interviews.

Sincere thanks to Professor Mike Cook, the project sponsor, and other SHA colleagues for their commitment and support, and to the SHA for part funding Phase 2 of the ImP project.

We are grateful to members of the NHS East of England Multi-professional Deanery Research and Development Stakeholder Group for their advice, guidance and wise counsel about how to tackle the various challenges that arose during the course of the project, largely due to the unprecedented volume of change within the NHS during 2010/11.

Liz Clark and Jan Draper
October 2011
EXECUTIVE SUMMARY

Background
There has been significant global investment in healthcare education directed at preparing a competent and flexible workforce that can meet both current and future healthcare demands. Yet despite this substantial expenditure and recognition that healthcare education should be more evidence based, there is limited empirical evidence of its effectiveness. Without such evidence, funding for CPD is likely to be cut back significantly, particularly in the context of having to make cost savings in excess of £20 billion across the NHS in England by 2014.

So the returns on the investment in CPD in terms of meeting organisational objectives and delivering better patient care are not well understood. There is also a lack of clarity about who is responsible for ensuring this return on investment.

The importance and complexity of evaluating the effectiveness of CPD has been widely discussed and there has been increasing interest in this area. However, remarkably little progress has been made over the past 20 years, which is perhaps indicative of the challenges and complexities involved.

Like many other healthcare educators, we have been struck by compelling feedback and anecdotal evidence from students provided in the context of module evaluations. These self-report data indicated the ways in which their learning had contributed to service improvement and innovation, and had boosted their confidence to question/challenge colleagues and local practice when appropriate to do so. However, in an era of evidence-based policy and practice, more is needed if investment in CPD is to be safeguarded.

Development of the Impact on Practice (ImP) framework: Phase 1
The aim of the first phase of the project was to develop a framework that would enable a range of key stakeholders to consider ways in which the impact of learning on practice could be maximised. This involved a structured literature review and in-depth conversations with stakeholders (commissioners of education, managers, health and social care educators, service users/representatives from patient organisations and learners).
An expert advisory group also contributed by providing high support and high challenge at every stage of the development process. In addition, the project team presented the framework at a number of national/international conferences and workshops to elicit feedback and suggestions from as many interested educators and practitioners as possible from health and social care, and the wider higher education sector.

Initial feedback was that the framework is easy to understand, user friendly, flexible and with potential applicability to wider health and social care settings. However, the framework was a theoretical one, and its merits could only be better understood by exploring stakeholder perceptions of the need for it and its utility.

**Evaluating the ImP framework: Phase 2**

In the context of the rapidly changing healthcare environment where variables are difficult, if not impossible, to control, conventional research approaches do not readily lend themselves to the evaluation of complex interventions and one size does not fit all (Mackenzie *et al*., 2010).

Although not widely used in healthcare, the project team adopted a realist evaluation (RE) approach because of its focus on context and process. Rather than trying to eliminate the influence of the real world, as attempted in traditional ‘scientific’ approaches, RE regards the ‘messy’ and ‘untidy’ world within which we live and work as influential to the evaluation process.

**Project aim**

The aim of the project was to examine whether the ImP framework might facilitate a positive impact on practice as a direct result of CPD and identify the particular circumstances that support this outcome. It complements separate projects undertaken by the University of East Anglia (UEA) and The Open University (OU). One of the UEA/OU projects examined outcomes, including an economic evaluation of CPD. The OU/RCN ImP project focused on processes and an exploration of ‘upstream’ influencing factors rather than outcomes *per se.*
Approach and methods
The project was undertaken in the geographical location overseen by the Norfolk County Workforce Group. Two hospital trusts and one primary care trust agreed to participate.

Semi-structured interviews were conducted with learners, managers, educators and board members to explore key issues relating to the impact of CPD on practice and their perception of the need for and usefulness of the ImP framework.

Round 1 interviews focused on issues relating to pre-selection and selection processes and the timing of these interviews was planned to coincide, as far as possible, with students starting their module studies, although those on a full programme of study had already completed some modules and were embarking on new ones. Interviews were conducted with 16 self-selected students (enrolled on a range of modules on a stand-alone basis or as part of a programme of study), 12 managers, 10 associated module leaders and 3 Board members (n = 41).

Round 2 interviews focused on the module experience and follow-up and were conducted at a time when students were part way through or had recently completed their studies. As far as possible, these interviews were conducted with the same individuals as for Round 1: 11 students, 11 managers, 8 module leaders and 2 board members (n = 32).

All the interviews were digitally recorded, transcribed verbatim and then thematic content analysis was undertaken for each of the stakeholder groups separately, for each round of interviews. The guiding principle of ‘what works’ and ‘what does not work’ was adopted to search for meaning across the data.

Findings
Four cross-cutting themes were identified from the combined data:

- Theme 1: **Organisational context** with two sub-themes: a) Strategic approach to CPD and b) Culture and process (in relation to the workplace, the education provider and shared across the two).

- Theme 2: **Partnership working** that is education provider led, workplace led and joint.
• Theme 3: **Supportive learning environment** in the workplace and education environment.

• Theme 4: **Attributes** of the learner, manager, educator and shared attributes.

These themes were comprised of numerous categories which are discussed in the main body of the report.

**Implications of the findings**

This evaluation provides the strategic health authority with insights into 'what works' and 'what does not work' in relation to the support of CPD and its use (or not) in practice. The project identified key features of the organisational context, including cultural issues and processes, which are crucial to maximising the impact of CPD on practice. It emphasised the importance of effective communication and partnership working, and in particular, the imperative for integrated planning that joins up service needs, education commissioning and learning provision. In our view, this would appear to be an essential ingredient that will help to inform future CPD investment in more productive CPD and contribute to more effective ways of allocating what is likely to be significantly reduced funding for CPD.

The key characteristics of a supportive learning environment in both the workplace and education setting were also identified. These characteristics appear to be influential in supporting effective learning and its utilisation in practice. The importance of a supportive clinical learning environment has long been recognised. Our project contributes further evidence of the vital contribution of effective learning environments.

It also identified important attributes of the learner, manager and educator that are likely to influence successful engagement with learning and the subsequent use of this learning in practice.

The `what does not work` categories in each of the themes highlight ways in which the impact of CPD can be significantly reduced. These issues need to be taken seriously if the return on investment in CPD is to be maximised during a period of financial constraint that may reduce funding available for CPD.
Key issues emerging from the data include:

- effective appraisal systems that address organisational as well as individual needs
- the importance of a supportive organisational culture and infrastructure within the workplace and education provider
- the need for education provision that is sufficiently flexible to accommodate workplace demands
- transparent recruitment and selection processes for CPD that are systematic and planned
- clarity about the support available for CPD (including fees, study time, mentor
- the crucial role of the manager in supporting CPD.

In short, addressing all these issues may mean organisations 'doing less better', thereby enhancing future return on investment and their reputation as 'learning organisations'.

Although the project findings largely confirmed what is already known about the challenges of ensuring that investment in CPD helps meet organisational objectives and improved patient care, they remind us that many of the issues highlighted in the literature over the past decade or more remain problematic and have yet to be fully addressed. It is hoped that interested stakeholders might focus on ensuring that those things that work become more embedded and that those things that do not work are tackled systematically to reduce their negative impact.

Furthermore, it is encouraging to note that the ImP framework highlights many of the elements in the proposed national NHS Educational Outcomes Framework (EOF) currently being developed by the Department of Health. The EOF is designed to make explicit the benefits of quality healthcare education and training on care delivery. Our focus on ‘upstream’ influencing factors should be helpful when considering how the EOF is to be implemented in the East of England – organisational context, partnership working, a supportive learning environment and the attributes of learners, managers and educators.
will continue to exert a crucial influence on the successful implementation of any national education and training outcomes framework.
INTRODUCTION

Investment in healthcare education

There has been significant global investment in healthcare education directed at preparing a competent and flexible workforce that can meet both current and future healthcare demands (Ansari, 2002; Mackinnon Partnership, 2007). Yet despite this substantial expenditure and recognition that healthcare education should be more evidence based (Greenhalgh et al., 2003), there is limited empirical evidence of its effect on professional practice and healthcare outcomes (Davis and Davis, 2010) or cost effectiveness.

A meta-analysis of 31 studies of the effectiveness of continuing medical education (CME) suggests that the effect size of CME on the knowledge of physicians is moderate, but that the effect size is small in relation to the performance of physicians and patient outcomes (Mansouri and Lockyer, 2007). A critical review of the economic evidence by Brown et al. (2002) concluded that the evidence base was ‘completely inadequate’ and did not ‘allow any empirical conclusions to be drawn about the economic value of continuing professional development’ (p.652). Others have highlighted similar issues about the relationship between continuing professional development (CPD) and benefits to patients, including the Royal College of Nursing (2004), Clark (2005a), Attree (2006), Griscti and Jacono (2006) and Cotterill-Walker (in press). This situation does not sit easily in the current national/international climate of evidence-based practice, quality, improvement, innovation, productivity and effectiveness, and means that increasingly CPD has become a political issue (Nolan et al., 2000).

Sayer and Gray (2006) remind us that:

Training is often seen as the solution to many problems in health and social care and we spend a substantial amount of money on training the workforce. However, for most training we really do not objectively know what the benefits are to trainees, service users, carers or health and social care organisations. (p.49)

Clearly, the return on the investment in CPD in terms of meeting organisational objectives and delivering better patient care are not well understood. There is
also a lack of clarity about who is responsible for ensuring this return on investment.

The importance and complexity of evaluating the effectiveness of CPD has been widely discussed (Eraut, 1985; 1994; Phillips et al., 2004) and there has been increasing interest in this area. However, remarkably little significant progress has been made over the past 20 years, which is perhaps indicative of the challenges and complexities involved (Phillips et al., 2004; Grant, 2011). Another reason, according to the Chartered Institute of Personnel and Development (2007), is that formal evaluation is regarded as too time-consuming and is, therefore, often neglected. This has resulted in organisations making decisions about education and training based on anecdote, reactions, hunches or inertia (Tannenbaum and Woods, 2002).

However, in a political and economic climate that demands value for money and evidence of effectiveness, the challenges associated with demonstrating impact on practice ‘are not enough to excuse complacency’ (Hutchinson, 1999, p.1269) or the current lack of progress. Without such evidence, funding for CPD is likely to be cut back significantly, particularly in the context of having to make cost savings in excess of £20 billion across the NHS in England by 2014.

As healthcare educators committed to finding ways of maximising the impact of CPD on practice, we were interested in trying to tackle this complacency.

**Purpose of CPD**

Reviewing the literature indicates that the purposes of CPD are wide ranging. The diversity and imprecise terminology used indicate that CPD is poorly defined and has different meanings for stakeholder groups. According to Roberts et al. (2001), CPD can help to ensure practitioners are fit for practice. Elsewhere, other purposes are emphasised, including improving service users’ health (Sayer and Gray, 2006), patient care (Nolan et al., 1995; Wildman et al., 1999) and healthcare outcomes (NHS Education for Scotland [NES], 2003; Gould et al., 2004). In addition, the literature refers to the purpose of CPD in terms of its wider impact on health and healthcare (Jordan, 2000; NES, 2003). This includes an emphasis on practice improvement in general terms (Jordan,
1998; Hardwick and Jordan, 2002), enhancing service quality (NES, 2003) and ensuring effective practice (Cowman, 2006) that meets the needs of the learner and service (Hicks and Hennessy, 2001). CPD also helps to meet mandatory training requirements, individual career plans and organisational needs (Gould et al., 2007).

The tension between the different individual, organisational and professional strands can sometimes present competing priorities when, for example, an individual’s wishes for CPD may not align with organisational strategy and needs (Munro, 2008). The literature also indicates that different stakeholders – commissioners, service managers, learners and educators – may hold different and, possibly, incompatible views about the purpose of CPD (Ellis and Nolan, 2005) which may in turn influence expectations regarding its impact (Roberts et al., 2001; Griscti and Jacono, 2006).

Given these wide-ranging and divergent views in the literature, it is important to establish a collective understanding of the purpose of CPD, as its purpose will influence expectations of impact and also ways of measuring this impact. Madden and Mitchell’s (1993) definition is helpful in drawing together these various strands. They define CPD as:

The maintenance of and enhancement of knowledge, expertise and competence of professionals throughout their careers according to a plan formulated with regard to the needs of the professional, the employer, the profession and society. (p.12)

This definition captures the individual, organisational, professional and wider societal aspects of CPD and the expectation that it will result in demonstrable outputs with respect to knowledge and skills.

Mindful of the wider context within which these definitions of CPD are located, it was nevertheless important for the project to adopt a pragmatic approach to defining CPD to ensure that all participants had a shared understanding of what was meant by CPD. Following consultation with key stakeholders at the project-planning stage, a relatively narrow definition of CPD was adopted for the purpose of this initial evaluation: **CPD is any accredited learning opportunity that includes a formal**
assessment of learning and contributes to the enhancement of the knowledge, expertise and competence of the learner. This meant that informal, bite-sized, non-accredited learning was excluded.

A broader definition may be adopted in any future project, but it was felt that a broader conceptualisation at the outset might make it more difficult to uncover ‘what works’ and ‘what does not work’ in terms of facilitating the application of new learning in practice.
BACKGROUND

Like many other healthcare educators, we became interested in some of the compelling feedback and anecdotal evidence from students gathered in the context of module evaluations (see Box 1). These self-report data indicate the ways in which their learning has contributed to service improvement and innovation, and had boosted their confidence to question/challenge colleagues and local practice when appropriate to do so.

Box 1: Anecdotal evidence of the impact of learning on practice

'I've developed an end-of-life care package for patients in my clinical area.'

'I've developed an end-of-life care package for patients in my clinical area.'

'Improved practice in our deep vein thrombosis service has impacted on patient care as a result of my learning.'

'Improved practice in our deep vein thrombosis service has impacted on patient care as a result of my learning.'

'My learning has made me challenge and question my nursing style.'

'My learning has made me challenge and question my nursing style.'

'I've got my dream job ... I still find it hard to believe that I’m actually doing what I’ve only dreamed about doing for so long. It’s a brilliant feeling to be able to go home at night with my head still buzzing with ideas of ways to improve older people’s care.'

'I've got my dream job ... I still find it hard to believe that I’m actually doing what I’ve only dreamed about doing for so long. It’s a brilliant feeling to be able to go home at night with my head still buzzing with ideas of ways to improve older people’s care.'

There has been a great deal of rhetoric about the benefits of lifelong learning on patient care and service delivery, but little robust evidence of the impact of CPD on practice and of the ‘health return’ on the financial investment (in terms of time and financial resources) in CPD (Draper and Clark, 2007). For example, the Department of Health asserted that ‘every aspect of healthcare delivery and strategies for health depends on the education and skills of individual staff. Investment in their learning and personal development is, in a real sense, spending on patients and is essential to the future quality of the health service’ (Department of Health, 2002, p.7, our emphasis). Given the significant investment, there is an imperative to demonstrate the impact of CPD on practice.

The imperative to demonstrate impact on practice

Clark (2005a, p.598) argues that evaluation should be a ‘central activity for every educator who is concerned about the effectiveness and impact of what
they do’. However, as already indicated, there is a lack of robust evidence concerning the impact of CPD on practice (Wildman et al., 1999; Hardwick and Jordan, 2000; Jordan, 2000; Daley, 2001; Clark, 2005b; Attree, 2006; Cotterill-Walker, in press). As a consequence, ‘we really do not objectively know what the benefits are to trainees, service users, carers or health and social care organisations’ (Sayer and Gray, 2006, p.49). This lack of evidence of the impact of CPD on practice is in stark contrast to the principles inherent in the evidence-based practice movement (Wildman et al., 1999; Carpenter et al., 2004; Clark, 2005b; Griscti and Jacono, 2006). Furthermore, Sayer and Gray (2006, p.1) argue that approaches to the evaluation of educational interventions should mirror the ‘rigour of that applied to the evaluation of complex interventions to improve health’.

Writing over a decade ago, Furze and Pearcey (1999, p.361) highlight the possible implications:

Unless more research is undertaken that demonstrates how CPE [continuing professional education] actually impacts on patient care, rather than nurses’ perception of outcome, then it will be very difficult to justify future expenditure of public money on CPE for nurses.

In order to secure continued funding for CPD to further service delivery and individuals’ career development, there is a definite need to provide evidence of the significant investment made in CPD (Nolan et al., 1995; Furze and Pearcey, 1999; O’Brien et al., 2001; Ansari, 2002; Clark, 2005a; Sayer and Gray, 2006). There is also a need to ensure that any demonstration of value is appropriate for the different stakeholders involved (Attree, 2006; CIPD, 2006).

**Defining impact on practice**

Having established the need for robust evidence of the impact of CPD on practice, it is important to consider what is meant by ‘impact’ and the various ways this question has been addressed.

Across the literature there is failure to define explicitly what is meant by impact on practice, with many authors either not addressing the issue of definition at all, or using terms such as ‘clinical effectiveness’ and ‘clinical outcomes’ interchangeably. What is clear is that there various ways in which impact on
practice can be interpreted, including impact on direct patient outcomes, patient safety, patient experience, the practice of educators, the working lives of practitioners/learners, the organisational context, helping learners learn how to learn, productivity, retention of staff, career progression and salary. Nolan et al. (2000) acknowledge this diversity and argue that:

‘...improvements to patient care may be seen as the main “raison d’être” for CPE [continuing professional education] but to consider CPE as successful only to the extent that patient care is improved is far too limiting.’ (p.462, emphasis in the original)

A number of typologies have been developed in various attempts to capture the different types of impact. Framing impact at individual, organisational and professional levels is one approach (Gould et al., 2007). Similarly, Hakkennes and Green (2006, pp.7–8) identified outcome measures at patient, practitioner and organisational levels, breaking these down into actual and surrogate impacts (see Table 1).

<table>
<thead>
<tr>
<th>Table 1: CPD outcome measures (Hakkennes and Green, 2006)</th>
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<tbody>
<tr>
<td><strong>Patient level</strong></td>
</tr>
<tr>
<td>1. Actual changes in patient health status: e.g. pain, depression, quality of life</td>
</tr>
<tr>
<td>2. Surrogate measures of the above: e.g. patient compliance, length of stay</td>
</tr>
<tr>
<td><strong>Practitioner level</strong></td>
</tr>
<tr>
<td>1. Actual changes in practice: e.g. compliance with guidelines</td>
</tr>
<tr>
<td>2. Surrogate measures of the above: e.g. knowledge and attitudes</td>
</tr>
<tr>
<td><strong>Organisational level</strong></td>
</tr>
<tr>
<td>1. Measures of change in health systems: e.g. policy change and costs</td>
</tr>
</tbody>
</table>

A framework created by Nolan and colleagues (2000) classifies potential positive outcomes of CPD at five levels: personal, professional (individual), professional (interpersonal), personnel (organisation) and profession. Meanwhile, Ferguson (1994) suggested four main categories: learner satisfaction; knowledge, skills and attitude change; change in practice; and ultimate quality of service.

Beyond the healthcare sector in teacher education, Guskey (2000) proposed that impact could be evident at five levels: participant reaction; participant
learning; organisational support and change; participants’ use of new knowledge and skills; and pupil learning outcomes.

Each of these typologies acknowledges the different levels of impact that CPD may have, ranging from the individual and learner-specific, through direct measurable changes to patient outcomes and then on to organisational and professional levels. Just as it is important to establish a shared understanding of the purposes of CPD, it is also important to distinguish the different types of impact in order to propose ways of demonstrating this impact.

Most of these typologies have been derived from the overarching framework proposed by Kirkpatrick over 50 years ago. Working within human resources training and its impact on organisational change, Kirkpatrick (1959; 1975; 1994) and, subsequently, Kirkpatrick and Kirkpatrick (2005) proposed four levels of change (or impact), with the complexity increasing progressively through the levels. Success at levels 3 and 4 is contingent on success at levels 1 and 2. According to Bates (2004), this framework has been successfully used for over 30 years in human resources development in for-profit organisations.

Table 2: Four levels of training evaluation (Kirkpatrick, 1994; Kirkpatrick and Kirkpatrick, 2005)

<table>
<thead>
<tr>
<th>Level 1: Reaction</th>
<th>How do learners react to the programme?</th>
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<tr>
<td></td>
<td>What is the measure of learner satisfaction?</td>
</tr>
<tr>
<td></td>
<td>How is the learning experience evaluated by learners?</td>
</tr>
<tr>
<td>Level 2: Learning</td>
<td>To what extent has learning occurred?</td>
</tr>
<tr>
<td></td>
<td>What are the effects on learners’ knowledge, skills or attitudes?</td>
</tr>
<tr>
<td>Level 3: Behaviour</td>
<td>To what extent has on-the-job behaviour changed as a result of the programme?</td>
</tr>
<tr>
<td></td>
<td>How has the transfer of learning into the workplace led to behaviour change?</td>
</tr>
<tr>
<td>Level 4: Results</td>
<td>What is the result of any changed behaviour resulting from the learning?</td>
</tr>
<tr>
<td></td>
<td>What are the effects on performance?</td>
</tr>
</tbody>
</table>

As part of a review of interprofessional education in the UK and building on Kirkpatrick’s levels of evaluation, Barr et al. (2000) added sub-levels to levels 2 and 4 as shown in Table 3.
Table 3: Adaptation of Kirkpatrick’s levels of evaluation by Barr et al. (2000, pp.10–11)

<table>
<thead>
<tr>
<th>Level 1: Learners’ reaction</th>
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<tr>
<td>These outcomes relate to participants’ views of their learning experience and satisfaction with the programme.</td>
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<table>
<thead>
<tr>
<th>Level 2a: Modification of attitudes/perceptions</th>
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<tr>
<td>Outcomes here relate to changes in reciprocal attitudes or perceptions between participant groups, towards patients/clients and their condition, circumstances, care and treatment.</td>
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<thead>
<tr>
<th>Level 2b: Acquisition of knowledge/skills</th>
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<tbody>
<tr>
<td>For knowledge, this relates to the acquisition of concepts, procedures and principles of interprofessional collaboration. For skills, this relates to the acquisition of thinking/problem-solving, psychomotor and social skills linked to collaboration.</td>
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<tr>
<th>Level 3: Change in behaviour</th>
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<tbody>
<tr>
<td>This level covers behavioural change transferred from the learning environment to the workplace prompted by modifications in attitudes or perceptions, or the application of newly acquired knowledge/skills in practice.</td>
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<table>
<thead>
<tr>
<th>Level 4a: Change in organisational practice</th>
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</thead>
<tbody>
<tr>
<td>This relates to wider changes in the organisation/delivery of care, attributable to an education programme.</td>
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<table>
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<tr>
<th>Level 4b: Benefits to patients/clients</th>
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</thead>
<tbody>
<tr>
<td>This final level covers any improvements in the health and well being of patients/clients as a direct result of an education programme.</td>
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</table>

It is clear from the literature that most studies attempting to evaluate impact focus on levels 1 and 2 only, while levels 3 and 4 remain largely neglected. A review of the literature commissioned by Skills for Health in England found that ‘much of the literature stops short and considers only the immediate benefits of education and training for healthcare professionals, and not whether those benefits ultimately also benefit patients’ (Mackinnon Partnership, 2007, p.5). Indeed, Bates (2004, p.344) argues that ‘it is often easier to develop a training program that will elicit positive reactions from participants than one that will lead to true learning and behaviour change on the job’.

Kirkpatrick and Kirkpatrick (2005) acknowledge that the transfer of focus from levels 1/2 to levels 3/4 represents a significant challenge for education evaluators. Although difficult to achieve, they argue that these higher levels are the most important: ‘If the trainees do not apply what they learned, the program has been a failure even if learning has taken place’ (Kirkpatrick and Kirkpatrick, 2005, p.6). The complexities associated with impact at levels 3 and 4 highlight the importance of the learning transfer process and the associated cultural/organisational environment in making learning effective (Bates, 2004).
Despite its uptake in the for-profit sector, Kirkpatrick’s model has been subject to some criticism. For example, it has been argued that the model should include a fifth level to capture return on investment and value for money (Mackinnon Partnership, 2007), and in a scholarly analysis, Bates (2004) critiques the model on the basis of its inability to support the principle of beneficence.

However, our analysis of the literature and subsequent work on the ImP project suggests that Kirkpatrick’s framework provides a helpful and systematic approach to defining levels of impact, and one that is likely to have shared meaning across the healthcare sector. We therefore endorse the view of the Mackinnon Partnership (2007) that ‘Kirkpatrick’s model still holds a good deal of value’ (p.29).

**Research approaches previously used**

The reasons for the limited evidence of the impact of CPD on practice partly reflect the types of study that have been conducted and the range of approaches used. These include randomised controlled trials, survey research and case study research.

**Randomised controlled trials**

Randomised controlled trials (RCTs) are widely regarded as the ‘gold standard’ for evaluating the effectiveness of interventions. However, despite their central position in the evidence-based practice movement, in the context of education evaluation, RCTs present operational challenges (Jordan, 2000) and their use with complex interventions has been called into question (Seers, 2007; Mackenzie et al., 2010). In 2008, the UK Medical Research Council issued new guidance to address some of the perceived limitations of its original guidance (published in 2000), including the ‘lack of attention to the social, political or geographical context in which interventions take place’ (p. 6).

As highlighted by Ellis et al. (2000), Attree (2006) and Sayer and Gray (2006), RCTs have rarely been used as an evaluation approach in healthcare education. However, a small number of studies have attempted to establish a causal link
between education and changes in practice using a RCT (see, for example, Gray et al. (2004) and Sayer and Gray (2006). In addition, some studies have used a quasi-experimental approach (e.g. Ellis et al., 2000; Wang et al., 2003). According to Sayer and Gray (2006, p.49), ‘randomised controlled trials are expensive and complex and their use in evaluating educational initiatives is challenging. However, only a RCT can tell us definitively whether a training package works’.

This optimism is not shared by everyone. Forsetlund et al. (2009) updated the systematic review by O’Brien et al. (2006) to establish if educational meetings (which included courses, conferences, lectures, workshops, seminars and symposia) enhance professional practice and healthcare outcomes. The original review, involving 32 studies, found poor reporting of studies. In particular, some accounts of the research design, sampling, follow-up and blinding were so limited that they were insufficient for the study to be replicated. Eighty-one trials, involving more than 11,000 health professionals, were included in the updated review which concluded that educational meetings alone, or when combined with other educational interventions, can improve professional practice and healthcare outcomes for patients, although the effects were often small, particularly when focusing on more complex behaviours.

**Survey research**

Questionnaires have been widely used in educational evaluation (see, for example, Hicks and Hennessy, 2001; Wilkinson et al., 2002; Hardacre and Keep, 2003; Willets and Leff, 2003; Espeland and Indrelius, 2003; Smith et al., 2006; West et al., 2006; Lee, 2011). They are frequently designed specifically for particular projects and therefore significant effort is required to construct a robust instrument that is valid and reliable. In some instances, focus groups or interviews are used to gather data (Hoover, 2002; Atak, 2003; Bahn, 2007a and b; Tame, 2011) or to inform questionnaire development (Carpenter et al., 2004).

However, the use of questionnaires as the sole method of data collection in education evaluation restricts the types of impact that can be investigated. They rely on respondent’s self-reported accounts (Silverdale and Katz, 2005),
provide a snap-shot of a single moment in time and, most importantly, do not go beyond Kirkpatrick’s levels 1 and 2.

**Other research approaches**

Other research approaches and methods used include illuminative evaluation (Ellis and Nolan, 2005); realist evaluation (Moore and Bridger, 2008; Oroviogoicoechea and Watson, 2009); case study research (Winters and Foggin, 2002; Greenhalgh *et al.*, 2003); phenomenology (Gunn and Goding, 2009; Donaldson, 2011); grounded theory (Currie *et al.*, 2007); mixed-methods research (Opfer and Pedder, 2010); and repertory grids (Johnston and Smith, 2005).

In summary, the existing evidence base is typically characterised by the following limitations:

- studies that are short-term, small-scale, programme-specific and confined to a single locality;
- over-reliance on the students as the key stakeholders, learner satisfaction, increased knowledge and skills, and the learning and teaching strategies employed;
- the data tend to be self-report;
- predominant use of retrospective methods with associated errors of recall and bias;
- insufficient account has been taken of the complexities of the practice environment;
- very few adopt a longitudinal approach and so sustainability is not examined; and
- of addressed, benefits to patients and service users are assumed rather than directly assessed.

Mindful of the limitations of this previous work, the ImP project was conceived out of a desire to investigate ways in which we, as healthcare educators, might maximise the impact of learning on practice.
Development of the ImP framework: Phase 1

The aim of the first phase of the project (2006–09), funded by the Higher Education Innovation Fund (HEIF3), was to develop a framework that would enable key stakeholders to consider ways in which the impact of learning on practice could be maximised.

Methods used to develop the framework

A structured literature review revealed a number of important emerging themes, including the importance of organisational culture, the influential role the manager plays in supporting (or not) the development of practice, and the partnership between the education provider and the service organisation. In addition, in-depth conversations with stakeholders (commissioners of education, managers, health and social care educators, service users/representatives from patient organisations and learners) were used to develop/refine the framework. According to the stakeholders we interviewed, what they need is an approach that is manageable in a pressurised working environment – by this they meant easy to understand and use, does not involve research, is not programme specific, and is dynamic and cost effective. In the words of one manager, ‘If successful, this could help us to sort out where we should be investing in the future – which courses and which providers. At the moment it’s largely guesswork’.

An expert advisory group also contributed to the development of the framework by providing high support and high challenge at every step of the process.

During Phase 1, the project team presented the framework at a number of refereed national/international conferences and workshops to elicit feedback and suggestions from as many interested educators and practitioners as possible from health and social care, and the wider higher education (HE) sector. This included a keynote presentation and a workshop using the ‘world café’ approach with a group of higher education lecturers at the Higher Education Academy Festival of Learning in 2009.
The ImP framework

The framework consists of four domains (see Figure 1); within each domain a number of influencing factors have been identified that highlight ways in which the impact of CPD on practice can be maximised by the organisation, manager, education provider and learner, and their associated responsibilities. These factors were identified from the health and social care, education and management literature, in-depth conversations with stakeholders and feedback.

**Figure 1: The Impact on Practice framework**

Time is represented in the framework as pre-selection, selection, during the delivery of learning, and following successful completion of learning. Different influencing factors operate at each of these stages and these are outlined in the framework.

The ImP framework has been positively received by a range of stakeholders. The feedback received at the end of Phase 1 was that the framework is easy to understand, user friendly, flexible and has potential applicability to wider health and social care settings than originally envisaged. Recorded comments included the following:
• “I like its simplicity. I could use this and would not be intimidated or put off from using it.” [Commissioner of education]

• “It isn’t going to be a framework that sits on a dusty shelf and gets referenced – it has the potential to be a really useful tool.” [Educator]

• “I don’t feel that I have anything other than admiration and excitement about this. ... I do not have anything else useful to contribute, except having the added leverage of people being aware and being able to ask how this is being implemented.” [Patient organisation representative]

It was comments such as these that inspired the project team to plan a follow-up study.

At that end of the first phase of the project, the framework remained theoretical, and its merits could only be fully understood if it was evaluated in practice. Phase 2 of the project involved a more systematic evaluation to explore stakeholder perceptions of the need for and utility of the ImP framework.

**Evaluating the need for and utility of the ImP framework: Phase 2**

It has already been noted that healthcare literature reveals how little is known about the impact of CPD. Furthermore, there are significant methodological challenges associated with attempting to capture and measure impact (Grant, 2011). Previous studies investigating the impact of CPD have used a range of approaches, including randomised controlled trials, surveys, illuminative evaluation and case study approaches. These all have their limitations and, consequently, have not been able to illuminate the higher levels of impact (levels 3 and 4). This has resulted in a partial and limited picture that is neither generalisable nor systematic (Ellis and Nolan, 2005).

In the context of complex and rapidly changing practice environments – the ‘messy’, real world of practice – where variables are difficult, if not impossible, to control, experimental or quasi-experimental research struggles to expose clear-cut, causal relationships between CPD and healthcare outcomes. In the words of Greenhalgh and colleagues (2003, p.145), ‘the linear and formulaic link between evidence and practice implicit in evidence based medicine proved
inadequate for the complexities of educational research’. Therefore, conventional approaches do not readily lend themselves to this kind of complex evaluation.

These ‘real-world’ issues are important. With respect to education evaluation, we know that the practice environment is complex and can either enable or disable learning (Ellis and Nolan, 2005). There is evidence that student support is important to the success of CPD (Hardwick and Jordan, 2002). Robust processes for selecting students to undertake CPD are also important (Ellis and Nolan, 2005) and Ferguson (1994) highlights the need for students and their managers to think carefully about selection. Jordan (2000) calls for a follow-up of the application of knowledge to practice, while Sharples et al. (2003) and Ellis and Nolan (2005) report little attempt by managers to do so, even when they have been involved in identifying who should undertake the education in the first place. Thus, the interplay between the learning itself and the practice context is crucial (Sloan and Watson, 2001).

Research approach
Although not widely used in healthcare settings, the project team decided that realist evaluation (RE) might address some of these issues because its methodological intent is to provide a more holistic picture of the phenomenon under investigation. Rather than trying to eliminate the influence of the real world, as attempted in traditional ‘scientific’ approaches, RE regards the ‘messy’ and ‘untidy’ world within which we live and work as crucial in the evaluation process (Pawson and Tilley, 1997; Kazi, 2003).

The context of Phase 2
The start of the ImP evaluation coincided with the publication of the English White Paper – *Equity and Excellence: Liberating the NHS* (Department of Health, 2010a), followed shortly afterwards by *Liberating the NHS: Legislative framework and next steps* (Department of Health, 2010b) – which proposes far-reaching changes in the NHS. Even in a service that has been subject to constant change and reorganisation since the 1970s, this policy context has resulted in unprecedented levels of upheaval and uncertainty across the NHS, which inevitably affected organisational and individual engagement with the
project. On occasions, initial commitment was subsequently withdrawn (e.g. due to service reorganisation or application for foundation trust status).
APPREACH AND METHODS

The purpose of the evaluation

The purpose of the project was to examine the ImP framework and explore the extent to which it might facilitate a positive impact on practice as a direct result of CPD, identifying the particular circumstances that support this outcome. The evaluation focused on:

- the ways in which learning opportunities are identified
- the process of selecting module/programme participants
- how practitioners engage with the learning experience
- how practitioners plan to use what they have learned to change or consolidate their practice
- how any planned change or consolidation is incorporated into practice
- the contextual issues within organisations that enable or inhibit the proposed changes.

Evaluation outcomes

The evaluation was designed to provide the strategic health authority with:

- an understanding of the circumstances where CPD investment benefits patient care and when they do not
- guidance on how CPD investment might be spent more effectively in relation to improving the patient experience
- an indication about how clinicians might expend more time on productive CPD
- an evidence base for aspects of the clinical learning environment standards.

In addition, the evaluation will enable the project team to explore how the ImP framework might be used in practice, identify any modifications that may be needed and how it might be used to best effect in the future. This project complements separate projects undertaken by the University of East Anglia (UEA) and The Open University (OU). The NHS East of England Multi-professional Deanery Research and Development Stakeholder Group overseeing both projects agreed that together the two projects will:
• create a framework and methodology to support the strategic management of commissioned CPD;
• identify the roles and responsibilities at an organisational, local and individual level to maximise the opportunities for commissioned CPD to have a positive impact on practice and service delivery;
• assist commissioners to determine best value for money investment in CPD;
• identify ways in which CPD commissioning can make a difference to services and to individual practitioners;
• ensure that CPD policy and practice are evidence-based and amenable to process management.

One of the UEA/OU projects focused on outcomes, including an economic evaluation of CPD, informed by drivers such as quality, innovation, productivity and prevention. Phase 2 of the OU/RCN ImP project focused on processes and an exploration of ‘upstream’ influencing factors.

Figure 2: The UEA/OU and OU/RCN projects

Research approach
Many writers have acknowledged that evaluation of CPD is difficult (see, for example, Jordan et al., 1999; Furze and Pearcey, 1999; Hicks and Hennessy, 2001; Sharpes et al., 2003; Ellis and Nolan, 2005). Methodological challenges
are further compounded by the range of stakeholders involved, including education commissioners, students, patients/service users, employers and educationalists. These stakeholders occupy different and potentially competing ‘paradigms’ (Nolan et al., 2000): an ‘orthodox’ paradigm which is concerned with sustaining professional and educational ideologies and a ‘corporate’ paradigm concerned with ensuring that employees are fit for purpose.

Conventional research approaches are limited in their ability to embrace these different and potentially competing dimensions and fail to demonstrate direct impact due to their inability to embrace the complexity of the work-based environments in which CPD is undertaken. Fraser (2006, p.196) describes the evaluation of educational programmes as more like ‘constructing a jigsaw than a one-shot photograph’. Furthermore, Greenhalgh et al. (2003) claim that ‘educational questions have a more complex taxonomy, a less direct link with particular preferred study designs, and no universally accepted criteria for assessing validity’ (p. 144).

Because of these methodological challenges, the project team chose to use a realistic evaluation (RE) approach. RE was developed in response to some of the challenges associated with measurement (Wilson and McCormack, 2006) and its methodological intent is to provide a more complete picture of the phenomenon under investigation. Rooted in critical realism, Pawson and Tilley (1997) suggest that RE provides an opportunity to consider evaluation from a realistic perspective. Evaluation and measurement are undertaken rigorously, but rather than trying to eliminate the influence of the real world, RE regards the ‘messy world’ within which social programmes operate as influential to the evaluation process. The setting in which the evaluation takes place therefore assumes equal importance with the ‘intervention’ or concept being evaluated (Wilson and McCormack, 2006).

In taking account of both the process and context of change, RE ‘presents nurses with a tactical resolution to evaluating innovative nursing practice and offers an explanatory dimension to evaluation’ (Wilson and McCormack, 2006, p.51). Therefore, whilst experimental research is concerned with attributing cause and effect, RE ‘demands a closer look at the way in which the variables
are connected. Thus, it enquires about the underlying causal mechanisms that bind them together and about how the individuals’ reasoning and resources, their choices and capabilities, are woven together’ (Befani et al., 2007, p.174.).

In a similar vein, Tolson et al. (2007, p.193) suggest that ‘realistic evaluation seeks to penetrate beneath the observable inputs and outputs of an intervention’. RE therefore emphasises the importance of context and tries to find out what works for whom in what circumstances (Pawson and Tilley, 1997, p.210, emphasis in the original).

RE has been used in a number of contexts, including social work practice and the health services (Kazi, 2003). However, it is relatively underdeveloped and ‘its methodological rules are still emerging’ (Tolson, 1999, p.389). It is not wedded to one particular epistemological or methodological point of view and ‘employs all appropriate methodologies, quantitative and qualitative, and is characterised by a laudable methodological pluralism’ (Thyer, 2004, p.488).

In summary, given the complexities associated with evaluating the impact of CPD on practice and the importance of organisational context, this project adopted a RE approach to try to understand the factors that influence the impact of CPD on patient care and why practitioners may or may not be able to implement their learning in their practice.

**Recruitment**

The project was undertaken in the geographical location overseen by the Norfolk County Workforce Group (CWG) – one of five CWGs within NHS East of England. All the local trusts and education providers in Norfolk were invited to participate, creating the potential for three acute trusts and two primary care trusts to be involved in the project. Two hospital trusts (James Paget University Hospitals NHS Foundation Trust and Norfolk and Norwich University Hospitals NHS Foundation Trust) and one primary care trust (NHS Great Yarmouth and Waveney) agreed to participate. A further acute trust and another primary care trust were in the process of applying for foundation status and therefore felt unable to commit to involvement in the evaluation. In addition, the two higher education institutions who provided the majority of the CPD for these trusts –
the University of East Anglia and University College Suffolk – agreed to participate.

In James Paget University Hospitals NHS Foundation Trust and NHS Great Yarmouth and Waveney Primary Care Trust, the education leads were proactive in contacting staff commencing courses in October 2010 and telling them about the project. In the other acute trust, nursing management undertook this role. With poor recruitment in this latter trust, there was an understandable reluctance to recruit participants more proactively because of concerns that this could be interpreted as unacceptable coercion.

Following initial contact by the trust education leads, students who expressed an interest in participating in the evaluation contacted the project manager. The inherent difficulty of accessing students who are not motivated to engage in CPD is acknowledged when participants self-select. Information sheets were provided, consent obtained (see below) and telephone interviews were scheduled at mutually convenient times. Students, predominantly nurses and some occupational therapists, were studying a range of modules on a stand-alone basis or as part of a programme of study leading to a qualification. The students were working in a variety of roles in specialist units, community teams, community hospitals and on acute wards. The modules included mentorship, school nursing, healthcare law and ethics, long-term conditions, acute care, non-medical prescribing, infection control and clinical education and assessment. Modules were at both undergraduate (level 6) and postgraduate level (level 7).

The original intention was to interview the managers of all the students who agreed to participate, but in some instances, students were reluctant for us to contact their managers or their managers did not respond to requests to participate. Only two of the managers whose details were provided by students were interviewed and, ultimately, we approached the trusts to enlist their help in recruiting more managers. The leaders of the CPD modules studied by the student participants were contacted and interviews arranged. In total, 16 students, 12 managers, 10 module leaders and 3 board members were interviewed in the first round of interviews (n = 41). The first round of
interviews was timed to coincide, as far as possible, with students starting a module, although those on a full programme of study had already completed some modules and were therefore embarking on a new one.

A second round of interviews was conducted between three and six months later with, as far as possible, the same individuals as for Round 1: 11 students, 11 managers, 8 module leaders and 2 board members (n = 32).

Problems were encountered with respect to recruitment, which were further compounded by significant uncertainty in the health services associated with service reorganisation in response to the White Paper. For example, responses to email invitations to participate were slow. In the context of high volumes of emails, several participants noted difficulties in responding to important emails in a timely fashion. The telephone interviews were equally problematic. Interviews often had to be rescheduled at the last minute due to clinical demands, and ward managers were often too busy to participate and, understandably, regarded clinical demands as their highest priority.

**Ethics**

As the project was regarded as an evaluation, and following SHA clarification, NHS research ethics approval was not required. Agreement was provided for the evaluation to proceed with the consent of the Norfolk Research Governance Committee and the individual service departments involved. Ethics approval was sought, and subsequently granted, from The Open University Human Participants and Materials Ethics Committee (see Appendix A). Ethical considerations of anonymity, informed consent and confidentiality were upheld throughout the duration of the project and data protection protocols were adhered to. A consent form was designed (Appendix B), together with information sheets for each of the stakeholder groups. Participants were given the opportunity to read these and ask questions prior to signing a form consenting to their participation.
Data collection and analysis

The project officer conducted in-depth interviews with each of the stakeholder groups: students, managers, module leaders and trust board members. These were predominantly telephone interviews to allow maximum flexibility for respondents to participate given their busy schedules. A small number of interviews were conducted face-to-face when respondents indicated that this was preferred and more convenient for them. All the student participants were willing to engage in the interviews in their own time, highlighting the challenges of participating in interviews in work time and a genuine commitment to the project.

The interview schedules for each stakeholder group were informed by the influencing factors identified in the ImP framework. This approach facilitated a structured and systematic interrogation of the framework.

Round 1 interviews with students focused on the selection process for their CPD study and how they are encouraged to use their knowledge to develop practice. Round 1 interviews with managers and board members explored the processes for identifying organisational needs and how these are aligned (or not) with the needs of individual staff members. Interviews with module leaders explored their initial views of the framework and how modules are developed and promoted. Interviews were up to one hour in length, were digitally recorded, transcribed verbatim and analysed using NVivo 9 to identify emerging themes.

Round 2 interviews were undertaken with the same individuals as for Round 1 and explored further the preliminary themes emerging from the first round of interviews, together with the module experience and follow-up. There was some attrition of participants between interviews due to high work demands, annual leave and relocation out of the area. As in the first round, all the second interviews were digitally recorded and transcribed verbatim.

Thematic content analysis was undertaken separately for each stakeholder group and for each round of interviews. The realistic evaluation approach of ‘what works?’ and ‘what does not work’ was adopted to assist the analysis and
the subsequent identification of themes cutting across both sets of interviews and all stakeholder groups.
FINDINGS

Four cross-cutting themes and associated sub-themes were identified as a result of the combined data analysis. These are illustrated in Figure 3 below.

Figure 3: Summary of themes and sub-themes

<table>
<thead>
<tr>
<th>Theme 1: Organisational context</th>
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<tr>
<td>a) Strategic approach to CPD</td>
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<td>b) Culture and process</td>
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<tr>
<td>- workplace</td>
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<tr>
<td>- education provider</td>
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<td>- shared</td>
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<th>Theme 2: Partnership working</th>
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<tr>
<td>a) Education provider led</td>
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<td>b) Workplace led</td>
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<td>c) Joint</td>
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<th>Theme 3: Supportive learning environment</th>
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<tr>
<td>a) Workplace</td>
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<td>b) Education provider</td>
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<th>Theme 4: Attributes</th>
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<tr>
<td>a) Learner</td>
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<td>b) Manager</td>
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<td>c) Educator</td>
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<tr>
<td>d) Shared</td>
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The data categories that comprise these themes are summarised in Tables 4–7. In the following sections, each theme (and any associated sub-themes) is discussed in turn, identifying ‘what works’ and ‘what does not work’, and using verbatim quotations to illustrate key messages.

Theme 1: Organisational context

We identified two sub-themes under ‘Organisational context’ – ‘Strategic approach to CPD’ and ‘Culture and process’.

a) Strategic approach to CPD

What works

Focusing on ‘what works’, a number of categories comprised this sub-theme concerning participants’ perceptions of the importance of service organisations
having a strategic approach to CPD. This strategic approach included organisational commitment to, and the support of, learning and development, including a clear understanding of how CPD can enhance practice and the use of service user feedback to inform the development of organisational strategy.

When discussing the important role of managers, participants spoke of the need to have a strategic approach to assist managers in their support of CPD. They also highlighted the need for ring-fenced funding for CPD and a clear understanding about how the funding is allocated. A dominant theme within the data was the important contribution of effective and regular staff appraisals that address organisational as well as individual needs. This integration of individual and organisational requirements was a powerful thread throughout the interview data, echoing the work of Munro (2008) who recommends a collaborative approach to structured development in order to meet both individual and organisational needs.

Participants also described how organisations should use CPD to assist the systematic and purposeful planning of change, rather than regarding it as merely the acquisition of new knowledge and skills.

I am really quite inspired by the organisation in terms of how ‘at the top of the agenda’ training is and the fact that we can have funding for it. [Board member]

It is about perhaps what the team want and what the plan for the organisation is and it is not necessarily just about our own individual goals. [Student]

So I feel in the future that we will have to tailor our CPD to make sure that the skill set our workforce holds are appropriate and supported. Unless we do that then we will not make, it will not make sense in terms of we will waste money ... tailoring the requirements to match the skills set and needs of the service and the individuals to line those up. [Board member]

What does not work
In relation to ‘what does not work’, comments referred to organisations placing emphasis on risk management, rather than on staff development, and having no formal education plans at either organisation or unit level. This left some participants feeling that CPD ‘was not connected to the day job’. Lack of clarity about what CPD is available and whether and how it is funded was also identified. Participants spoke of the financial pressures affecting the funding for CPD and the consequent impact on protected study time. This generated
anxiety about the security of future funding and associated implications for
students who were enrolled on a programme pathway and working towards a
qualification. There were also comments about how it felt to self-fund courses
that would enable them to do their job better.

I suppose we are almost, with regret, drifting into risk management too quickly
because we are risk adverse by definition, in terms of clinical practice anyway. [Board member]

I am not a priority, so I don’t get any funding or I have to fight to get anything, which I
have had to do that just recently and the first module I have had to self-fund. [Student]

Even though we try as managers to predict and promote forethought one doesn’t
always get the time and by the time we are reminded of it is kind of first come first
served and I think that places have been so difficult to get hold of anyway recently,
I think some areas feel a bit hard done by really. [Manager]

There is no corporate structure at the moment to, who goes first and does what.
[Manager]

Participants also described the lack of expectation in organisations that there
should be follow-up about how their learning would be used and a lack of
organisation process to support and evaluate impact on practice. Alongside this
lack of expectation, there was also poor understanding of the limits of
individual’s ability to initiate changes in practice. This was compounded by
cultural differences between units within the same organisation. Inadequate
feedback from managers about CPD requirements and the appropriateness and
benefits of the CPD undertaken were also identified in interviews.

And then I guess it is the fact that we don’t challenge those people when they have
done training. We don’t, we really don’t challenge them about what they are putting
back into the service, you know. We don’t have the processes in place to do that.
[Board member]

[The non-medical prescribing course] made a significant change and enhancement to
my practice. I am not sure about the expectations that they had because I think there is
a good proportion of nurses who will go through six months of a pretty difficult course to
become an independent medical prescriber and have not had the support at work or
the confidence to actually prescribe themselves. I prescribe regularly every day and I
find it very useful. I am not sure there were huge expectations. I think it was really up to
me if I wanted to prescribe I could prescribe. [Student]

b) Culture and process

The second sub-theme under ‘Organisational context’ was ‘Culture and
process’. The categories in this sub-theme were organised under the headings
of ‘workplace’, ‘education provider’ and ‘shared’ (across the two).
What works in the workplace

Using the same approach, the ‘what works’ categories in the workplace included the importance of having clear and accessible organisational plans including CPD priorities. An organisational culture that had positive attitudes to CPD and change, a commitment to professional development plans and clear internal selection processes for courses were also identified. Participants described the need for managers to have clear expectations about how students should make use of their new knowledge in practice and, crucially, managers who support them to do so. Participants also described the importance of having a culture and process for feeding back to the organisation following completion of CPD, including mechanisms to cascade their learning.

Education provider: what works

With respect to the education provider, the ‘what works’ categories included the need for flexible education provision that accommodates and responds to clinical workload demands. Formative as well as summative module evaluation was also highlighted, with participants describing the value of face-to-face evaluation rather than ‘tick box’ computer-generated evaluations.

What works across the workplace and education provider (i.e. shared)

With respect to the categories shared across the workplace and education provider, opportunities to relate theory to practice and relate practice experiences to learning in the classroom, in assignments and when working in practice, featured strongly in the interview data. Having a shared understanding of the meaning of impact on practice was also identified. The celebration of achievement and success, and an acknowledgement of the sacrifices made, were regarded as important.

In some areas, for example the work-based learning module, it is a requirement that during the first couple of weeks of the module we, the key lecturers, work collaboratively with the student and their manager to devise bespoke objectives for the project that the student will take forward, identifying what resources and time the partner organisation needs to give them to allow them to do it. So that is actually part of the module and its assessment. That is absolutely explicit all the way through.

[Module leader]
What does not work in the workplace

The ‘what does not work’ category included employees feeling remote from the wider organisation and not valued by their organisation/unit/ward/team. Participants also highlighted organisational processes that act as barriers and inhibit change. These included hierarchies that affect the flow of information and stifle change, governance processes that make change difficult to initiate, poor communication channels, lack of time due to clinical demands, which was compounded by reduced staffing levels, increased throughput and higher patient dependency. Linked to this, were constant external changes that make it more difficult to focus on developing practice. A lack of transparent and equitable selection processes for CPD was also highlighted.

There isn’t the continuity of experience in terms of putting those things into practice in the workplace. Part of that is the HEI’s problem. A big part of it is our problem. Because we should be being much more active in engaging our nurses on courses in changes we expect them to undertake in practice. [Manager]

We need to do more to enhance what people gain from the courses and how they bring that knowledge back and that is why I am going to have a showcase event and try and get people to share the research and their evidence they bring back. [Manager]

I guess it is a case of we will get them onto the courses, we will support them through the courses and hopefully they will come out shining the other side and then it kind of goes quiet really. So we expect them to apply their knowledge as it were but we don’t follow it up really. We certainly don’t formally and proactively follow it up. [Manager]

And if you are going to put someone through an educational course, which is going to make a difference to their grading then it should be very clear what you expect to come out of that … I don’t think we have ever done that with staff nurses. [Manager]

[At a previous workplace] I had to pass on my knowledge. Here you are supposed to but they don’t enforce it … Although they say you are going to pass it on, nobody really has got the time to check if you are passing things on to people. [Student]

What does not work: education provider

In relation to ‘what does not work’, education providers were not always clear about who was being sent on courses, as they undertook student selection for the postgraduate provision only. The other issue identified was the use of online module evaluations with little incentive to complete them, resulting in poor response rates.
Theme 2: Partnership working

‘Partnership working’ was the second theme and categories were organised according to whether they were education provider led, workplace led or led jointly by the education provider and workplace.

a) Education provider led

The ‘what works’ categories included education providers having flexible module presentation dates, being able to respond to the needs of service and ensure learning content reflects changes in practice. The effective cascading of promotional material and module information to the appropriate leads in the clinical areas was considered to be important, and this included advanced information about module availability and dates. Short, locally provided induction courses that include managers were also regarded as a helpful approach.

The ‘what does not work’ categories included knee-jerk reactions to service demands to put on new courses, little or no guidance for managers about the content of and requirements for modules and a lack of information from education providers about who has and who has not successfully completed modules.

Probably over the last five years, I don’t know how many hours I have wasted, trying to find out the learning outcomes, marking criteria, that kind of stuff. I need that kind of thing to help me and most of the time they don’t have it. [Manager]

b) Workplace led

The ‘what works’ category identified by participants included clear service engagement in the activities of curriculum development, monitoring and evaluation. However, the converse was also acknowledged that clinical demands often restricted service involvement in this type of activity even when there was a genuine commitment to do so.

c) Joint

A number of ‘what works’ categories were identified and these emphasised the importance of good working relationships between education and service providers. This included clear and direct communication mechanisms and
participation in stakeholder meetings to discuss the range of learning provision. A shared understanding and commitment to maximise the use of new knowledge in practice was also regarded as important. Other categories included collaborative evaluation involving all stakeholders, and use of feedback from mentors, supervisors and managers, as well as students, to inform module development.

I hope our partner organisations consider how they could help people to plan what they are going to do before they come here, and to also use and disseminate the learning when they get back. [Module leader]

The ‘what does not work’ categories included poor communication between education providers and managers, and information about CPD not getting to the appropriate people in a timely fashion. Lack of clarity and follow up regarding how students use knowledge in practice and who is responsible for encouraging students to use their new knowledge in practice were also highlighted. Module evaluations that do not take account of impact on practice and delays in enrolment that subsequently delay students’ access IT facilities and other resources can also have a negative influence.

Theme 3: Supportive learning environment

The third theme focused on the features of a ‘Supportive learning environment’ in the workplace and the education setting.

a) Workplace

With respect to ‘what works’, categories included the need for transparency and mutual understanding about what the organisation and the individual will each contribute in terms of study time and fee support. Linked to this was the need for organisations to be transparent and equitable in the way in which study time was allocated. A key feature was the interest and encouragement shown by the manager and the importance of having a supportive, work-based supervisor, mentor or critical friend. The availability of sustained support when studying a programme pathway assisted student’s consolidation of learning.

Students reported that having the opportunity to talk about their studies and learn from each other was important to them, including support and
encouragement from those who have previously studied. They also found it helpful to know someone who had previously completed the same module, or if their manager was studying or who had done so recently (a ‘fellow sufferer’).

You can then feed off other people as well and you take into account other peoples’ practice areas. We are quite a diverse group … there is a whole range of different types of people with different experiences … and it is good to network … to be able to apply it perhaps in a different context. [Student]

The contrasting ‘What does not work’ categories included managers who are too weighed down by clinical priorities to support the development of staff. Time constraints, including 12-hour shifts, made study leave problematic and this was compounded by a perceived inequity in allocation of study leave between students, echoing similar concerns highlighted by Bahn (2007b). Students reported the negative impact of studying on their days off and how this affected their ability to recover from the demands of the job.

Yeah, well just being released from work has been a nightmare to be honest. I have been given literally four hours a week to study the Masters-level modules, which is not good, and having to do basically half a day at work and then go across to university, or do half a day at university and then come back to work. [Student]

b) Education provider
Aspects of a supportive learning environment in the education setting included clarity about module requirements (for example, reading lists and the requirements at different academic levels). Guidance on how to use tutors and academic advisers, and help for students for whom English is not their first language, were also identified as helpful.

We suggested to all trusts and managers that when people have been out of study for a period of time they should come along to one of our two post-registration induction short courses, which gives people a real kind of warm-up to academic writing, using Blackboard, understanding what academic requirements are, how you need to prepare yourself for study and so on, and students report that if they do that that link-in was helpful. [Module leader]

‘What does not work’ categories included the inflexibility of education providers in relation to attendance and module assessment deadlines, varying quality of teaching and first-time students being unprepared for the amount of work required.
Theme 4: Attributes

The final theme was concerned with ‘Attributes’ – those of the learner, manager and educator.

a) Learner

‘What works’ categories included students who are keen to learn and have enthusiasm and a positive attitude towards CPD and change. Being able to sustain the enthusiasm that develops when studying was considered to be important, as was students’ understanding their responsibility to share their learning.

I feel part of me had something to prove to myself and part of me enjoys studying. I actually get quite a kick out of it because it makes me realise that I am not stupid. [Student]

‘What did not work’ were students not wanting to learn because they were ‘sent’ on courses, who were frightened of studying or who lacked confidence. Anxious students, those with poor IT skills, poor time management skills and poor English language skills were among the negative attributes highlighted. In addition, student’s reluctance to seek help and/or share their learning was identified.

b) Manager

The manager’s enthusiasm for, and positive attitude towards, CPD was frequently cited as a key feature of ‘what works’. Also of crucial importance was a manager who is open to change, proactive, energetic, inventive, creative, and who leads by example.

I have had that conversation with one of my staff who is doing an MSc because I have said to her that I expect her to lead research, to get a real finger in the pie, and she needs to do this, this and this, and be on this and this group because she will need to do that kind of stuff when she has got her MSc, but I don’t think that kind of conversation happens very often. [Manager]

In contrast, ‘what does not work’ is a manager who lacks both the time and the skills to facilitate changes in practice:

She’s not interested in education whatsoever and she doesn’t particularly promote courses. You have to really, really ask to do them and I think that is why a lot of us now are paying for our own. She is very much on a budget and she is not interested in
your personal career development. She is just interested in numbers and figures and things like that. [Student]

c) Educator

The ‘what works’ attributes of educators included clinical credibility and up-to-date knowledge. Educators who are skilled facilitators of learning (not merely ‘teachers’) and who draw on students’ existing knowledge were also highlighted as being important.

We felt that there should have been a higher expectation of our knowledge base before we went into it and so that was fed back through [to the module leader]. [Student]

d) Shared

Attributes that appeared to be shared between the learner, manager and educator included the need for a mutual understanding of the commitment required between manager and student. Fostering a questioning and critical approach to practice and having a clear career plan that is linked to appraisal were also regarded as important.

The themes, sub-themes and categories are summarised in the four tables on pages 46 to 50.
Table 4: Summary of categories in Theme 1 – Organisational context

<table>
<thead>
<tr>
<th>Organisational context</th>
<th>a) Strategic approach to CPD</th>
<th>b) Culture and process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What works</strong></td>
<td><strong>What does not work</strong></td>
<td><strong>What works</strong></td>
</tr>
<tr>
<td>Contribution of County Workforce Group to education commissioning</td>
<td>Organisational emphasis on risk management rather than staff development</td>
<td></td>
</tr>
<tr>
<td>Organisational commitment to and support of learning and development, including understanding how CPD can enhance practice</td>
<td>No formal educational plan at organisation and unit level; CPD that is not connected to the day job</td>
<td></td>
</tr>
<tr>
<td>Service user feedback that informs organisational strategy</td>
<td>Lack of clarity about what CPD is available and funded</td>
<td>Clarity and accessible organisational plans, including CPD priorities</td>
</tr>
<tr>
<td>Organisational understanding of CPD requirements</td>
<td>Apparent ad hoc allocation of CPD funding that is not matched to service needs</td>
<td>Positive attitudes to lifelong learning and changing healthcare practice</td>
</tr>
<tr>
<td>A strategic approach to assist managers in supporting CPD</td>
<td>Financial pressures impacting on funding for CPD including study leave; anxiety about future funding and implications for completing a full programme pathway</td>
<td></td>
</tr>
<tr>
<td>Ring-fenced CPD money and clarity about its allocation</td>
<td>Having to self-fund for courses that enable you to do your job better</td>
<td></td>
</tr>
<tr>
<td>Effective and regular staff appraisals that address both organisational and individual needs</td>
<td>Organisation’s lack of expectation that there should be follow up about how new knowledge is being used; lack of organisation process to support and evaluate impact on practice</td>
<td></td>
</tr>
<tr>
<td>Recognising the importance of focusing on planned change rather than merely the acquisition of new knowledge</td>
<td>Lack of understanding in the organisation of the limits of individuals to be able to initiate changes in practice, including different unit cultures within the same organisation</td>
<td></td>
</tr>
</tbody>
</table>

**b) Culture and process**

<table>
<thead>
<tr>
<th><strong>What works</strong></th>
<th><strong>What does not work</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarity and accessible organisational plans, including CPD priorities</td>
<td>Employees feeling remote from the wider organisation</td>
</tr>
<tr>
<td>Positive attitudes to lifelong learning and changing healthcare practice</td>
<td>Not feeling valued by the organisation/unit/ward/team</td>
</tr>
<tr>
<td>Managers who are clear about their expectations of students to make use of their new knowledge in practice and who support them to do so</td>
<td>Constant external changes which make it difficult to focus on developing practice</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>Valuing each other’s knowledge, skills and expertise</td>
<td>Organisational processes act as barriers and inhibit change (e.g. hierarchies which stifle change, governance processes that make change difficult to initiate, poor communication channels, hierarchies affecting the flow of information, lack of time due to clinical demands compounded by reduced staffing levels, increased throughput and higher patient dependency)</td>
</tr>
<tr>
<td>Commitment to PDPs</td>
<td>Not making critical reflection part of the working ethos</td>
</tr>
<tr>
<td>Clarity about the internal selection process for courses</td>
<td>Lack of transparent and equitable selection processes for CPD</td>
</tr>
<tr>
<td>A culture and process for feeding back to the organisation following completion of CPD, including mechanisms to cascade the knowledge gained</td>
<td></td>
</tr>
<tr>
<td>Staff who are motivated and proactive in introducing change</td>
<td></td>
</tr>
<tr>
<td>Engaging the support of medical colleagues in planned changes</td>
<td></td>
</tr>
<tr>
<td><strong>Education provider</strong></td>
<td></td>
</tr>
<tr>
<td>Flexible provision to accommodate clinical workload demands</td>
<td>Education provider not always clear about who is being sent on a particular course; student selection only controlled by the education provider for postgraduate provision</td>
</tr>
<tr>
<td>Formative as well as summative module evaluation, and which is face to face rather than ‘tick box’ computer generated</td>
<td>Online evaluations with little incentive to complete and therefore poor response rates</td>
</tr>
<tr>
<td>Changing modules in response to feedback</td>
<td></td>
</tr>
<tr>
<td><strong>Shared</strong></td>
<td></td>
</tr>
<tr>
<td>Shared understanding of what impact on practice means</td>
<td>Length of time to complete full qualification when studying part-time</td>
</tr>
<tr>
<td>Opportunities to relate theory to practice in the classroom, in assignments and on return to practice. Similarly opportunities to relate practice experiences back to learning</td>
<td></td>
</tr>
<tr>
<td>Celebrating achievement and success and acknowledging sacrifices made</td>
<td></td>
</tr>
</tbody>
</table>
### Table 5: Summary of categories in Theme 2 – Partnership working

<table>
<thead>
<tr>
<th>Partnership working</th>
<th>a) Education provider led</th>
<th>What works</th>
<th>What does not work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>An education provider’s ability to respond to the needs of service and ensure content reflects changes in practice</td>
<td>Knee-jerk reactions to service demands to put on courses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Flexibility of module presentation times</td>
<td>Lack of guidance for managers about module content and requirements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cascading promotional material and module information effectively to leads in clinical areas, including advanced information about module availability and dates</td>
<td>Workload implications of adopting workplace assessments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Timely enrolment with education provider</td>
<td>Lack of information from the education provider about who has/has not successfully completed modules</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Short, locally provided induction courses that include managers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Workplace led</td>
<td>Service engagement in education provider’s curriculum development, monitoring and evaluation</td>
<td>Clinical demands restrict service involvement in education provider activities</td>
</tr>
<tr>
<td></td>
<td>c) Joint</td>
<td>Good working relationships between education and service providers; direct communication with education provider including stakeholder meetings to discuss the range of learning provision</td>
<td>Poor communication between the education provider and managers; information about CPD not getting to the appropriate people in a timely fashion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shared understanding and commitment between education provider and workplace to maximise the use of new knowledge in practice when students return to practice</td>
<td>Lack of clarity and follow up regarding how students use knowledge in practice and who is responsible for encouraging students to use their new knowledge in practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collaborative evaluations involving all stakeholders</td>
<td>Enrolment delays that result in students’ inability to access IT, for example library and learning environments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Using feedback from mentors, supervisors, managers and students to inform module development</td>
<td>Module evaluations that do not take account of impact on practice</td>
</tr>
</tbody>
</table>
Table 6: Summary of categories in Theme 3 – Supportive learning environment

<table>
<thead>
<tr>
<th>Supportive learning environment</th>
<th>What works</th>
<th>What does not work</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a) Workplace</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What works</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transparency and mutual understanding about what the organisation and the individual will each contribute in terms of study time and fee support</td>
<td></td>
<td>Managers who are too weighed down by clinical priorities to support staff development</td>
</tr>
<tr>
<td>Transparent and equitable allocation of study time</td>
<td></td>
<td>Inequity of study leave between students</td>
</tr>
<tr>
<td>Interest and encouragement from manager</td>
<td></td>
<td>Time constraints – too many demands on time including 12-hour shifts making study leave problematic</td>
</tr>
<tr>
<td>Supportive clinical-based supervisor/mentor/critical friend, facilitated by manager</td>
<td></td>
<td>Negative impact of studying on days off affects ability to recover from job demands</td>
</tr>
<tr>
<td>Opportunity for students to talk about their studies and learn from each other, including support from those who have previously studied, knowing someone who has previously completed the module, or having a manager who is studying or has done so recently ('fellow sufferers')</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sustained support for students on a programme pathway which can help to consolidate learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>b) Education provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What works</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clarity about module requirements (e.g. reading lists) and what is required at different academic levels</td>
<td></td>
<td>Inflexibility of education providers in relation to attendance and deadlines</td>
</tr>
<tr>
<td>Guidance on how to use tutors and academic advisers</td>
<td></td>
<td>Varying quality of teaching</td>
</tr>
<tr>
<td>Studying in mixed academic-level groups enhances learning</td>
<td></td>
<td>First-time students unprepared for the amount of work required</td>
</tr>
<tr>
<td>Help for students when English is not their first language</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 7: Summary of categories in Theme 4 – Attributes

<table>
<thead>
<tr>
<th>Attributes</th>
<th>a) Learner</th>
<th>What works</th>
<th>What does not work</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What works</td>
<td>Realisation that studying can be enjoyable and you can do it</td>
<td>Students who do not want to learn, who are frightened of studying or who lack confidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Students who are keen to learn and have enthusiasm and a positive attitude towards CPD and change</td>
<td>Anxious students</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sustaining the enthusiasm that develops when studying</td>
<td>Students with poor IT skills, time management skills and poor English language skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Student’s understanding of their responsibility to share their learning</td>
<td>Reluctance to seek help and/or share knowledge</td>
</tr>
<tr>
<td>b) Manager</td>
<td>What works</td>
<td>Manager’s enthusiasm for and positive attitude towards CPD</td>
<td>Managers who lack time and the skills to facilitate changes in practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Manager who is open to change, proactive, energetic, inventive, creative and leads by example</td>
<td></td>
</tr>
<tr>
<td>c) Educator</td>
<td>What works</td>
<td>Educators who are clinically credible and up to date</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Educators who are skilled facilitators of learning (not merely teachers) and who can draw on students’ existing knowledge</td>
<td></td>
</tr>
<tr>
<td>d) Shared</td>
<td></td>
<td>Understanding by the manager and the student of the commitment required</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fostering a questioning and critical approach to practice</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Having a clear career plan that is linked to a PDP</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Helping practitioners grow in themselves and develop</td>
<td></td>
</tr>
</tbody>
</table>
Reflections on the findings

The four themes that emerged from the data, although articulated differently, echo the constructs identified by Manley et al. (2009) in their concept analysis of work-based learning. One of their ‘enabling factors’ was a **supportive organization-wide infrastructure**, which included reference to partnership working. This mirrors the ‘culture and process’ sub-theme of Theme 1 (‘Organisational context’) and Theme 2 (‘Partnership working’).

Their other enabling factor was an **organization-wide learning philosophy** which is similar to the ‘strategic approach to CPD’ sub-theme of Theme 1 and Theme 3 (‘Supportive learning environment’). Another key construct of their framework for work-based learning was **attributes** relating to the **learner, workplace activity, resources and workplace infrastructure**. This reflects Theme 4 (‘Attributes’) and also makes further links to our other themes.

The underpinning principles of ‘what works’ and ‘what does not work’ which are intrinsic to the realist evaluation approach adopted, resonate with the **best practice** and **poor practice** dimensions identified by Ellis and Nolan (2005) in their longitudinal evaluation of CPD. Moreover, many of the elements they identify mirror several of our categories. For example, the nature of the selection process, staff disposition towards learning, the quality of the educational experience and the nature of the practice milieu.

In addition to the parallels outlined above, the findings have encouraged us to think more carefully about the metaphor of a learning journey as a means of conceptualising CPD. Our previous use of the terms ‘pre-selection’, ‘selection’, ‘during CPD’ and ‘following CPD’ does not powerfully capture the notion of this journey. The language used by Ellis and Nolan (2005) – ‘going in’, ‘coming out’, ‘reaping the benefits’ and ‘carrying it on’ – may provide a useful organising architecture when revisiting the ImP framework.

Despite the relatively small-scale nature of this project, the findings of Phase 2 confirmed many of the influencing factors in the original ImP framework. However, the current economic climate, resulting in increasingly pressurised
environments in both the healthcare and higher education sectors, means that we have revised the influencing factors to focus on those elements that were deemed to be crucial and eliminate the 'nice to have' factors originally derived from the wider literature. This streamlined version, involving no more than eight factors in each domain, should help to ensure that the framework remains fit for purpose and will continue to be useful to stakeholders by highlighting only the essential issues as a first step in tackling the ongoing challenges.

It is encouraging to note that the ImP framework highlights many of the elements in the proposed national NHS Educational Outcomes Framework (EOF) currently being developed by the Department of Health (2011a, http://www.nwhcs.nhs.uk/news-proposed_nhs_educational_outcomes_framework___how_will_it_work_.html), based on the NHS Outcomes Framework 2011/12 (Department of Health, 2010c) and the Public Health Outcomes Framework (Department of Health, 2011b).

The EOF is designed to make explicit the benefits of quality healthcare education and training on care delivery and enable 'further research to directly link education and learning to improvements in patient care outcomes’ (para. 2.2, Department of Health, 2011a). It is regarded as 'a unique opportunity to reshape the education and training of the future workforce to ensure that the NHS is able to achieve the best possible health outcomes for patients and service users ... and ensure that we develop the right values, behaviours and team-working to provide person-centred care’ (para. 1.2, Department of Health, 2011a). The focus of the ImP framework on ‘upstream’ influencing factors should be helpful when considering how the EOF is to be implemented in the East of England. Organisational context, partnership working, a supportive learning environment and the attributes of learners, managers and educators will continue to exert a crucial influence on the successful implementation of any national education and training outcomes framework.
IMPLICATIONS OF THE FINDINGS

The main contribution of this evaluation to the strategic health authority is the identification of ‘what works’ and, most importantly, ‘what does not work’ in relation to the support of CPD and its use (or not) in practice. The project has identified key features of the organisational context, including cultural issues and processes, which are crucial to maximising the impact of CPD on practice. It has also emphasised the importance of effective communication and partnership working, and in particular, the imperative for integrated planning that joins up service needs, education commissioning and learning provision. In our view, this appears to be an essential ingredient that will help to inform future CPD investment in more productive CPD and contribute to more effective ways of allocating available funding for CPD.

The key characteristics of a supportive learning environment in both the workplace and education settings were also identified. These characteristics would appear to be influential in supporting effective learning and its utilisation in practice. The importance of a supportive clinical learning environment has long been recognised (for example, Orton, 1981; Fretwell, 1982; Ogier 1982). Our project reinforces this work and contributes further evidence of how effective learning environments can maximise the return on CPD investment.

The project also identified some important attributes of the learner, manager and educator that are likely to influence the successful engagement with learning and the subsequent use of this learning in practice.

The ‘what does not work’ concepts in each of the four themes highlight ways in which the impact of CPD can be significantly reduced. These issues need to be taken seriously if the return on investment in CPD is to be maximised.

Key issues emerging from the data include:

• effective appraisal systems that address organisational as well as individual needs
• the importance of a supportive organisational culture and infrastructure within the workplace and education provider
• the need for education provision that is sufficiently flexible to accommodate workplace demands
• transparent recruitment and selection processes for CPD that are systematic and planned
• clarity about the support available for CPD (including fees, study time, mentor
• the crucial role of the manager in supporting CPD.

In short, addressing these issues may mean ‘doing less better’ in the future, thereby enhancing the return on investment.

**Conclusions**

Although the project findings largely confirmed what is already known about the challenges of ensuring that investment in CPD helps meet organisational objectives and improved patient care, they remind us that many of the issues highlighted in the literature over the past decade or more remain problematic and have yet to be fully addressed. It is hoped that interested stakeholders might focus on ensuring that those things that work become more embedded and that those things that do not work are tackled systematically to reduce their negative impact. This should help to maximise return on investment during a period of financial constraint that may reduce funding available for CPD.

The imperative is as great as ever to prioritise these issues in order to eliminate what might be regarded as the ‘lost benefits’ of practitioners who have invested valuable time and energy to enhance their knowledge and skills and who are not always making best use of their learning in their workplace. Senge, who originally put forward the concept of a ‘learning organisation’ in 1990, claims that the organisations that will ‘truly excel in the future will be the organizations that discover how to tap people’s commitment and capacity to learn at all levels in an organization’ (Senge, 2006, p.4). Never has the
need been greater to capitalise on the accumulated intellectual capital and expertise developed through CPD to enhance organisational performance, particularly with the current emphasis on quality, innovation, patient safety and productivity against a backdrop of significant cuts in public funding.
REFERENCES


Appendix A

Ethics approval from The Open University Human Participants and Materials Ethics Committee (see next page)
This memorandum is to confirm that the research protocol for the above-named research project, as submitted on 12th May 2010, is approved by the Open University Human Participants and Materials Ethics Committee, subject to satisfactory responses to the following:

You are asked to:

1. Take particular care to assure the anonymity of what is a small (and thus more easily identifiable) number of institutions, module leaders and managers;

2. Note that data from any OU computer is routinely backed up and thus exists on a number of devices. Thus, it is recommended that data linking individuals and organisations to their respective data are stored separately from the main dataset.

At the conclusion of your project, by the date that you stated in your application, the Committee would like to receive a summary report on the progress of this project, any ethical issues that have arisen and how they have been dealt with.

John Oates
Chair, OU HPMEC
Appendix B

Consent form

Evaluation of the Impact on Practice (ImP) framework

Professor Jan Draper, Dr Liz Clark and Dr Shelagh Sparrow

1. I confirm that I have read and understand the information sheet for the above evaluation. I have had the opportunity to consider the information, ask questions and I have had these answered to my satisfaction.

2. I understand that the information collected in this evaluation will be confidential, anonymous and protected and that any personal information about me (name and contact details) will be stored on a password accessed computer at the Open University and kept separately from interview data.

3. I agree to take part in the above evaluation on these conditions and I give permission for information collected during the interview to be used in any presentation of the research findings with the understanding that my anonymity will be assured.

Name of participant: __________________________  Date: __________  Signature: __________________________

Name of person taking consent: __________________________  Date: __________  Signature: __________________________