Compilation of relevant sections from the notes of five meetings to prepare the work of the joint HOSPEEM-EPSU WG “CPD/LLL” and to advance on a joined declaration/statement.

Introductory remark

The task of the Working Group is described as follows in the Joint HOSPEEM-EPSU Work Programme 2014-2016 (http://www.epsu.org/a/10361):

- Theme: Recruitment and retention of healthcare workforce
- Sub-theme: Stating the importance of the role that Continuing Professional Development plays in recruiting and retaining staff
- Objective: Stimulate the creation of a learning environment in healthcare institutions both through formal and on-the-job training through a commitment to a professional lifetime guarantee of CPD for all healthcare professionals
- Elaboration of a Common Statement on the importance of ensuring access of healthcare workers to continuing professional development for both newly qualified recruits and more experienced health professionals to keep updated given an ageing population and an increased demand for high quality healthcare service.
5. Joint HOSPEEM-EPSU Working group on Life-Long Learning (LLL) and Continuous Professional Development (CPD) – Kick-off
   o Identification of the cornerstones for the work of the joint working group
   o Discussion with HOSPEEM and EPSU members on the main findings and recommendations of DG SANCO study presented in December 2014  
   o Towards the elaboration of a joint statement on the importance of ensuring access to LLL and CPD for all healthcare staff in the EU

To start the discussions, Tjitte Alkema (HOSPEEM) recalled what was agreed in March 2014 on the theme of CPD and LLL in the HOSPEEM-EPSU work programme 2014-2016. He added that this working group especially intended to work towards the elaboration of a joint statement on the importance of ensuring access to LLL and CPD for all healthcare staff in the EU.

He also presented a pyramid on CPD related topics, with quality of care and patient safety at the top and the recognition of professional qualifications and CPD at each of the bottom angles. He explained that these 3 topics had to be seen in a connected perspective and that quality of care and patient safety were paramount.

During this session, several participants from HOSPEEM and EPSU¹ made a brief intervention, reflecting on the issue of CPD from their national perspective. They presented the overall functioning of the CPD system in their country, some challenges and problems faced and some interesting initiatives taken in this area.

The main points raised during the discussions are the following:

- LLL and CPD should not be limited only to the 5 main health professions as there are many more professions in the healthcare sector. The joint working group therefore needs to reflect on how to apply CPD and LLL not only to the 5 automatically recognised health professions according to Directive 2013/55/EU (doctors, nurses, midwives, dentists and pharmacists) but also to all other healthcare workers. It is essential to invest in training for people that are below the professional qualification level of these professions (e.g. for health care assistants/auxiliary nurses). In the UK, there is a well established system of CPD for the regulated professions. However, 40% of the health workforce responsible for 60% of the patient contact gets about 5% of the training budget.

- Training should be available for everybody and across the life course. This is part of sustainable training policies and links to EPSU and HOSPEEM joint work on retention.

- It is necessary to increase awareness of the importance of CPD, encourage institutions to make necessary investments in all employees (irrespective of age, type of work/employment contract and without discrimination) and prevent administrative burden.

- Some major problems and obstacles regarding access to CPD were raised, namely funding, quality of support among organisations and time made available to undertake CPD. CPD appears not to be always financed by employers but also partly or fully by the worker herself/himself.

- The role of CPD and LLL in recruiting and retaining staff has to be highlighted. Moreover, the link between CPD, retention and sustainable ageing workforce has to be underlined. An

¹ Contributions from HOSPEEM members from Italy, Norway, The Netherlands and The United Kingdom. Contributions from EPSU affiliates from Belgium, Germany, Sweden and The United Kingdom.
example from the UK made the link between mandatory CPD and re-validation systems for the regulated professions (to check that health workers stay “fit for practice”).

- It is crucial to better train not only individuals but also teams.
- The working group should focus on how to motivate workers to open up to the idea of LLL and CPD and reflect on the kind of tools that could be used in this respect.
- Cooperation between employers and trade unions at local and national level on the issue of LLL and CPD works well and should therefore be promoted. An example from Norway was given in this context concerning the case of supply of sterile equipment and training, focused on health professionals with qualifications below university level.
- Involving several levels of government (national, regional, local) and taking local specificities into consideration when designing CPD systems is very important. An illustration for the government-based activities was given from Italy where since 2002 there is a national programme on CPD that links a national plan with regional plans. A national commission defines the main objectives for the process of education and the contents of CPD.
- Different levels of training can be identified. In the framework of the joint working group, initial and post graduate training outside the workplace should not be included. The work should focus on training going beyond/building on the post graduate training.
- The working group should look into the different training systems: compulsory, legal or individually required.
- A good match between facilities, funding and required training is needed. The short country report on Germany referred to a range of financing models that exist for CPD for different professions, including by collective agreements, by the employer (due to legal requirements, e.g. regarding the knowledge of staff about instruments used), often also in the framework of LLL/CPD plans on the organisational level that are co-defined as to the LLL/CPD needs by representatives of the employer and of trade unions.
- The working group has to respect the different existing national legal frameworks and should collect best practices, also at an early stage of the process to base further work on them.

As far as the DG SANCO study on LLL and CPD for health professionals in the EU is concerned, some participants stressed the fact that for some countries and professions the findings were wrong and that it was therefore difficult to discuss and use the conclusions and recommendations set out in the report. Moreover, this study only relates to the 5 recognised professions under the Directive on the Recognition of Professional Qualifications.

Tjitte Alkema said that the joint working group on LLL and CPD had to think about how to deal with this final report. According to him, this report should be considered as a context document and as extra bonus information and should be used where relevant. He added that if there were inaccurate elements in the country reports, it was necessary to report them.

The working methods of the joint working group on LLL and CPD were also discussed. As no funding is available for organising meetings outside of the Sectoral Social Dialogue setting and as it seems difficult to coordinate the work only via email, it was decided to identify and gather 2 or 3 people from each side to further proceed. This small steering group will coordinate the work of the joint working group (made up of approximately 15 people) and will have the possibility to meet at its own initiative to work towards the joint statement. Dates are not set yet for the ad-hoc meetings of the small steering group, but the Secretariats were asked to coordinate a proposal on this.

It was agreed to have a further debate on CPD and LLL on 15 June 2015 at the occasion of the second meeting of the Sectoral Social Dialogue Committee meeting for the Hospital Sector. Tjitte Alkema concluded by saying that it would be good to already advance work before the June meeting.
2) Preparatory Meeting 27.05.15

HOSPEEM-EPSU Steering Group on
Continuous Professional Development (CPD) and Life-Long Learning (LLL)
Brussels, 27 May 2015, 14.30-15.30
Synthesis of the discussions

Participants
- HOSPEEM: Tjitte Alkema, NVZ, HOSPEEM Secretary General; Emilie Sourdore, HOSPEEM Secretariat; Marta Branca, ARAN (via phone); Jeannette de Graauw, NVZ; Kate Ling, NHS
- EPSU: Marco Borsboom, FNV Zorg en Welzijn; Susan Williams, RCN (via skype); Mathias Maucher, EPSU Secretariat; Mounia Boudhan, EPSU Secretariat

The meeting served the purpose of preparing and pre-structuring agenda item 4 of the SSDC HS of 15 June 2015, i.e. the second meeting of the joint HOSPEEM-EPSU Working Group on CPD and LLL for health workers in the hospital sector. It dealt with possible thematic priorities, with the structure and elements of the planned joint declaration and with contributions by selected HOSPEEM members and EPSU affiliates. Ideas were also exchanged on how to organise the work on the joint declaration between June and December 2015. This document will be presented to the participants of the meeting for further debate and is to be read alongside the notes of the SSDC HS of 6 March 2015.

- General remarks on the joint declaration:
  - The joint declaration should be inspiring and incentivising, but not a prescriptive document.
  - The joint declaration should be as practical as possible and drafted in a way to be of use for the social partners at national, sectoral and enterprise level.
  - There is an opportunity to link the HOSPEEM-EPSU joint declaration to the DG SANCO Study on the mapping of CPD of health professionals in the EU. The DG SANCO study focuses on CPD for 5 automatically recognised health professions (doctors, nurses, midwives, dentists and pharmacists). It can be regarded as a reference document and used in the joint work of EPSU and HOSPEEM on CPD/LLL where relevant.

- Structure of the joint declaration:

  There was general agreement that the joint declaration should consist of 2 parts, containing a statement of principles on CPD/LLL for health workers in the hospital sector, followed by examples of existing good practices underpinning these principles.

  Identifying the success factors of good practices when gathering them was highlighted as an important element. It is indeed crucial for social partners across Europe to know what makes/can make the difference, what underlies good practices and what makes them work.

- Content of the joint declaration:

  It was agreed that the joint declaration should be structured along 4 or 5 thematic areas identified as relevant for the social partners in the hospital/health care sector in the field of CPD and LLL. Good practice examples should be primarily identified and collated for the selected thematic areas, but could very well also be presented for other relevant topics not dealt with in detail in the joint declaration.
Main priority issues that should be covered by the joint declaration:
- Linking CPD to the organisational performance related to the organisational objectives for improving the quality of care/care outcomes. CPD has to be tied into the priorities of the organisation to work well. It appears important to look at and to distinguish between the individual level, the team level and the impact on the organisational performance.
- Quality assurance system and quality framework of organisations: CPD/LLL can be linked to these systems and frameworks using i.e. annual appraisals and personal portfolios as instruments.
- Other important issues/aspects: Barriers and incentives to CPD; access to training across the life course; equality of access across different working patterns (e.g. part-time work), age groups and professional groups; funding; availability of (working) time; motivation of staff.
- Mandatory versus non-mandatory CPD/LLL. This issue also relates to the funding of the training and funding mechanisms/schemes in place.
- Mutual responsibility of the employer and the employee. CPD is not a one way responsibility from the employer but a two way responsibility. This topic is linked to the issue of motivation to participate in CPD/LLL.

The business case and need of investments into CPD/LLL for the age groups over 45 (currently experiencing under-investment and not enough attention) was highlighted.

As already discussed on 6 March 2015 during the first meeting of the joint HOSPEEM-EPSU working group on CPD & LLL, it was reaffirmed that the joint declaration should focus on the access to CPD and LLL for all health workers, not only on the 5 automatically recognised health professions (doctors, nurses, midwives, dentists and pharmacists) covered by the study published by DG SANCO.

Different forms in which CPD/LLL can be organised have been identified: vocational training; participatory learning and/or formal training/education; E-Learning and/or B(lended)-Learning. This aspect should also be covered.

- **Purpose and use of the joint declaration:**

  Main purposes of the declaration:
  - The joint declaration should primarily be used to influence and help frame what social partners do in the field of CPD in the different EU Member States. The declaration should serve as an inspirational document for HOSPEEM and EPSU members to create new and innovative solutions in the field of CPD at national level to make CPD/LLL work (better/more effectively). The joint declaration should make it possible for social partners to make a difference in the field of CPD. Social partners at European, national and local levels should make use of the joint declaration.
  - It should also be a useful tool to influence policy initiatives from the European Commission (DG MARKT and DG SANTE) on CPD and LLL.

- **Working methods and next steps:**

  On June 15th, during the second meeting of the HOSPEEM-EPSU working group on LLL & CPD, as on March 6th, there will be 3 joint presentations from members of the working group in order to present examples of good practices.
  It was agreed that there would be joint presentations from Italy, the Netherlands and the United Kingdom.
  In addition, a colleague from the European Centre for the Development of Vocational Training (CEDEFOP) has been asked to make an intervention during the meeting. Her availability still has to be confirmed by CEDEFOP.

  The necessity of reflecting on how to follow-up on the work done on June 15th was underlined. Members of the working group and the steering group (N.B.: its composition still needs to be decided for the EPSU delegation) indeed need to see how they can draft the declaration between June 15th and December 10th.
4. Joint HOSPEEM-EPSU Working group on Life-Long Learning (LLL) and Continuous Professional Development (CPD)

- Reporting back from the exchange of views between HOSPEEM and EPSU (and the meeting planned on 27 May 2015) to identify the cornerstones and deliverables for the work of the joint working group
- Identification of relevant existing material/experience (studies, social partners’ agreements, etc.)
- Revisiting the main findings and recommendations of DG SANCO study (http://ec.europa.eu/health/workforce/docs/cpd_mapping_report_en.pdf) presented in December 2014 to identify relevant elements for our own work
- Agreement on points to be covered in a joint statement on LLL and CPD for healthcare staff in the EU

Tjitte Alkema reported back from a preparatory meeting organised in Brussels on 27 May 2015 in order to identify the cornerstones of the planned joint declaration of HOSPEEM and EPSU on access to CPD for all health workers in the EU, to reflect on the structure and the main contents and to come up with a suggestion on the work process. [for more info => notes of meeting, to be read with the notes of the last meeting of the SSDC HS of 6 March 2015 when the issue was first dealt with]. This document and the notes of the WG 1/2015 have been distributed and are the starting point for today’s exchange.

The following points were raised during the discussion:

- There is a clear difference – in terms or scope, entitlement to, funding basis, workers’ responsibility, etc. – between CPD and LLL for the different professions and professionals/workers in the health sector. E.g. in Germany CPD (“Berufliche Fort- und Weiterbildung”) falls into the responsibility of the employer that also has to pay for it (fully or to a large share). There are also collective agreements dealing with the access to CPD in large companies. On the other hand LLL is defined as an element of adult education which implies a funding responsibility from public authorities and covers contents that are not only related to the professional qualifications needed for a certain (current or future) “job“ or function”. CPD and LLL are broader than formal education. What is meant by CPD and LLL needs to be clarified in the joint declaration. Moreover, the distinction between CPD and LLL as to different dimensions needs to be fully reflected in the future HOSPEEM-EPSU joint work that should focus on CPD.
- There are different forms of professional and formal CPD and LLL. We can distinguish academic/theoretical and participatory CPD. This also needs to be reflected in the joint work and joint declaration. This also holds for the distinction between work-related and job-related CPD. CPD for teams is also important.
- The issue of time availability is crucial. A replacement for employees on training is necessary.
Various countries have regulation requiring regular upgrades ("fit for practice") for different health professions such as nurses, midwives and doctors for them to be entitled to continue exerting their profession. Qualifications upgrading should be directly linked to the position a worker is currently active in or the position he/she is preparing himself/herself for.

This aspect is linked to one purpose of CPD important for employers, workers and patients, namely the quality of the services provided. CPD insofar contributes to a quality assurance policy in hospitals (as one important field of action for hospital employers in terms of HRM). CPD and quality of care are interrelated.

Another aspect that needs to be covered in the HOSPEEM-EPSU joint work (and tackled in practice at national level) is the access to CPD across all age groups (also for workers 45+) and across all professions/functions. It is necessary to invest in qualifications in the long run.

The joint declaration should highlight the key role of access to CPD for effective retention and recruitment policies in the sector. Investing in CPD can help creating attractive career pathways.

It should also underline – and underpin – with good practice the role of social partners in the design, delivery and evaluation of CPD. Trade union colleagues from France underline divergent opinions on the roles and responsibilities vis-à-vis CPD with orders of medical professions, a current topic of debate with high priority for them. The role of professional organisations vis-à-vis trade unions in the field of CPD needs to be carefully looked at.

The purpose of the joint document is also to influence future policy initiatives of the EC as a possible follow-up e.g. to the DG SANTE CPD Study (published in December 2014, together with an Executive Summary in all EU languages).

Points agreed/Action points/Deliverables:

- It was agreed that the points raised, in addition to what was already discussed and "concluded" in the meetings of 6 March 2015 and 27 May 2015, should be summarised in a paper that would serve as starting point for the working group members. This is a task for both secretariats. This document would then be circulated, with indications on how to proceed and to start the work, by the two secretariats.

- Both secretariats were asked to see with their "delegates" in the joint WG which of the colleagues would be interested and available to form a "core" group to start with the concrete drafting of the joint statement. This work would be done in English only. A meeting of this small steering group could take place at the end of September of beginning of October.

- A first draft of the joint declaration should then be presented and discussed at the Plenary Meeting of the SSDC HS 2015 on 10 December 2015.

- HOSPEEM members and EPSU affiliates were requested to send in relevant examples and good practices (also involving social partners) to improve the access to and outcomes of CPD to take along in the joint declaration.

Mathias Maucher informed EPSU had reached out to researchers at the European Centre for Vocational Education and Training (CEDEFOP) working on CPD to see to which extent their work could be used when drafting the joint ESPU-HOSPEEM statement and also if they were interested in being informed about our work and even possibly "involved" at some point. The CEDEFOP expert on CPD could not joint the meeting due to other professional obligations but had shared publications with the EPSU Secretariat (passed on to the HOSPEEM Secretariat) that could be "exploited" where appropriate by the Working Group on CPD.

N.B. 1: Summary information on the presentations made at the meeting is copied below and included in the notes of the meeting of 15.06.15 put @ page http://www.epsu.org/a/11361.

N.B. 2: The slide sets of the presentations made at the meeting have been uploaded to page http://www.epsu.org/a/11360, at the bottom.
Colleagues from The Netherlands, Norway and the United Kingdom gave joint presentations on different aspects of VTE/CPD policies in their countries and the role of social partners. The slide sets of the presentations have been shared with/circulated to the members by both secretariats. Key points also taken up in the discussion (see above) are summarised below.

**Presentation NL** (Jeanne Antoinette de Graauw, NVZ / Marco Borsboom, FNV Z&W)

- **Political aim of CPD:** Maintaining and optimising patient safety and quality

1. **Collective labour agreement in hospitals**
   - Non-mandatory CPD and LLL right for all employees
   - 3 percent of the average wage-budget per hospital is spent for CPD, taken out of available care budget
   - Formal procedures: 1) Access to/participation in CPD is monitored by works councils; 2) There is a complaint procedure for workers in case of non-selection; 3) Organisation of an annual performance review

2. **Collective grant for general hospitals**
   - Starting point: Non-mandatory CPD for all employees – Output-centred system – Objective: Incentive to increase the level of competence of all healthcare professionals to better prepare them and the health system in view of future demands
   - Procedure: Employer requests training for the employee which is approved by the works councils and the board (thus it is linked to demand of/in a concrete health care institution).
   - Amounts: The amount of EUR 1.3 billion € earmarked for CPD, based on an agreement between the government and the social partners for 2014-2017, is evenly distributed between hospitals by the Ministry of Health when an employer applies for the grant. This grants was also used as a “sticking plaster” to partly compensate cuts decided by the Health Ministry.

3. **Quality assurance systems for nurses and health care assistants**
   - A programme of “mandatory” CPD for nurses and health care assistants was negotiated between the Ministry of Health and the professional organisation of nurses.
   - This programme is only mandatory within the own professional group, but not legally mandatory
   - It’s a “conditional sales” programme, i.e. membership in the professional organisation is required to have access to the courses
   - The programme introduced training/educational courses with examinations and is organised alongside the professions. There is no direct link with job requirements.
   - There are also no quality assurance checks. Social partners try to work on quality assurance systems for CPDs. A Strategic Training Plan per health care institution has to be submitted by the employer. The lacking link to the quality requirements is contented and criticised by both sides of the social partners. Social partners have no influence in this scheme.

**Presentation N** (Signe Hananger, Fagforbundet & Trond Bergene, Spekter)

**Vocational Training and Education**

Norway has a long tradition of social dialogue. There has been a cooperation between the social partners, among others via joint conferences, to achieve common objectives, e.g.:

a. Ensure that Norwegians receive high quality care in hospitals.

b. Share good practices on interoperability, encouraging full time work, education and training, attractiveness.

c. Uncover – together with a research institute – the reasons behind young people’s education choices. This is particularly important, because Norway is expecting to have a severe shortage of nurses/nursing staff in 10-15 years. The possibility for have better access to CPD was found to be central, also vocational training was necessary.
The social partners are involved in tripartite structure with the national government and in a joint advisory group that has a strong mandate for upper secondary education. The social partners are striving to reinforce the cooperation, both bipartite and tripartite, on tertiary vocational education and training. N.B.: It is noteworthy that some practical nurses in N continue working beyond 65.

Presentation UK (Kate Ling / NHS Employers; Helga Pile, UNISON / Gill Coverdale, RCN)

Context

- A recent evaluation report states that the major challenge is to implement the government commitment to invest in CPD.
- The NHS constitution states that all staff should get CPD and LLL.
- Health Education England pays the training, including both pre- and post-qualification training.
- Education of support staff/health care assistants is traditionally underfinanced. In response to this, the Care Certificate has been introduced, which means that a person cannot practice as a health care assistant unless they have it.
- Career pathway: What is more needed is work-based training for HCA opening the door for upwards professional mobility and to become a nurse or a midwife

Examples

1. The Shape of Caring Review
   - The Shape of Caring review is the Health Education England reviewing the sector and bringing forth recommendations.

2. Training for Patient Safety
   - Training in whistleblowing when safety standards are drastically low, both for workers and management.

3. The Talent for Care
   - The strategy is initiated by Health Education England (HEE), social partners and other stakeholders. It concerns all staff. Healthcare support staff constitutes a great part of the health sector, but the training of care professionals is minimal; the idea is to shift this. There are three streams:
     o ‘Get in’ – attracting a wider and more diverse workforce, by giving them sense of progression routes in the field; career opportunities.
     o ‘Get on’ – making sure that all staff have development reviews and have a structure of qualifications within their role.
     o ‘Get further’ – to make it easier for people like HCAs to progress into nursing, midwifery, or pharmacy qualification without pushing them to give up their job.
   - This is delivered through social partnership at the local level, but a national social partnership structure is set up to oversee the delivery. The commitment to the Talent for Care is manifested in the employer signing the Partnership Pledge, which involves soft requirements. Funding is a bit piecemeal, therefore the social partners are looking into making a case for more funding, despite budget freezes.

4. The Clinical Leadership Programme (CLP)
   - CLP is created to develop nurses leadership skills through coaching and leading on a service improvement project. CLP is targeted at nurses who aspire to, or are employed in, a team leadership role, e.g. a ward manager. Leadership in nursing is recognised as fundamental to ensure safe and effective care. Leadership influences organisational culture. CLP is delivered locally via RCN approved facilitators, and the nurses are supported by their employer to undertake the programme.

5. The Advanced Nursing Practice (ANP)
   - ANP is a level of practice rather than a role or job title. The RCN has actively promoted ANP through the development of Master level education, competences and accreditation. The
university works with the commissioning employing organisations to ensure the programmes meet practice requirements. The programmes are supported from the employing organisations from design to delivery, including financial support.

The following points were raised during the discussion focusing on the presentations (for the thematic exchange on other aspects, see the list of bullet points):

- It was added that RCM also provides leadership programme for midwives across the UK. There are various programmes and conferences for both midwives and support workers (HCA).
- Important success elements mentioned in the good practices are a sustainable funding structure, time availability to participate in further training (this also relates to replacement of employees).
5. Joint HOSPEEM-EPSU working group on Continuous Professional Development (CPD) and Life-Long Learning (LLL)

- Update on the working process and methods of the working group
- Presentation of the first version of the joint declaration on CPD and LLL for health workers in the EU elaborated by the “drafting committee”
- Presentation of additional input provided by the broad working group
- Discussion with HOSPEEM and EPSU members
- Agreement on next steps

Mathias Maucher informed the participants that it had been agreed during the HOSPEEM-EPSU Steering Committee that further work on the joint declaration on CPD and LLL was needed. Emilie Sourdoire explained the whole process of drafting of the first version of the joint declaration since the first discussions held on the issue in March 2015.

Tjitte Alkema highlighted the importance of CPD and LLL, an issue that is to become prominent in the hospital/health care sector in the next years. He stated that the EU level, and more particularly the SSDC HS, should set the pace in this field with the adoption of an inspirational document that could be used by hospital/health care sector social partners at national level.

Kate Ling, NHS (United Kingdom), highlighted the really good start made and welcomed the overall agreement on the objectives and underlying principles.

Maryvonne Nicolle, CFDT Santé Sociaux (France), said that the main headings and the core principles could be considered as agreed and that it was now necessary to go deeper. She stated that this declaration should serve as a supporting document for social partners to influence decisions taken in this field at national level. She expressed her wish to see the idea of training as an investment and a wealth for the organisation, the employee and the patient further developed. She would also like the respective role and responsibility of the employer and the employee regarding training to be addressed more extensively.

Tjitte Alkema pointed out that the differentiation between CPD and LLL was so far not clearly enough phrased in the document and that a change in the text was therefore necessary, a point also supported by Herbert Beck, ver.di (Germany). He reaffirmed that social partners should look at training from the perspective of investment and not of cost. He also stressed the need to recognise CPD and LLL as a joint responsibility of employers and employees and to grant access to training to all types of professions and all age groups. He particularly put the emphasis on older workers and up to now often neglected further training needs and offers for this group of workers as a rule facing longer work careers.

A participant suggested referring to night shift workers and their particular problems in accessing CPD or LLL in the document, the latter often being a forgotten group.

Some thorny issues for which final formulations are still to be found were raised by the participants, such as the financing of CPD and LLL activities and the time made available to take part in such activities. It was agreed that having further discussion on those issues was needed.

The Chairwoman stated that the topic of CPD and LLL should not be left to the professional organisations as they would exclude a large share of professionals. Social partners should therefore be the leaders of any initiative in this field. The document should also underline the
organisational added value of investment in CPD and of having a strategic plan for access of the personnel to CPD and LLL.

The link between an investment in CPD and LLL and the provision of quality care and patient safety, the need to consider changes in ICT when designing CPD policies or programmes as well as the increase of obesity amongst patients, of multi-morbidity, of cardo-vascular diseases and of cancer were other aspects mentioned as relevant for social partner-based initiatives in the field of CPD and LLL during the exchange.

With regard to the time frame for finalising and adopting the joint declaration, it was said that there was no formal deadline but that EU social partners should not wait too much to provide inspiring guidelines for employers' organisations at national level as they were currently in the forefront. It was said that the text could potentially be adopted in June 2016.

It was agreed that it should be the task of the working group on CPD and LLL to add or delete some parts of the text and – where appropriate and agreed – to change the order of key points.

The Chairwoman reminded the participants that they could send their comments on the text of the joint declaration to their respective Secretariat.

Mathias Maucher kindly invited HOSPEEM members and EPSU affiliates to share examples of good practice that could be included in the annex in the run-up to the 2 March 2016 meeting of the SSDC HS with the two secretariats. He also announced that EPSU would translate the document to allow now in a second round for a smooth bottom-up process and for discussions of the draft document by EPSU affiliates in a larger number of countries.

It was agreed that during the next meeting of the SSDC HS, on March 2nd 2016, the participants would discuss a revised version of the joint declaration and that good practice examples should be prepared in a way to allow an exchange on how the examples or “cases” should finally be best presented in the annex to give incentives to look into these examples from other countries.
2. Joint HOSPEEM-EPSU working group on Continuous Professional Development (CPD) and Life-Long Learning (LLL)

- Presentation of the revised version of the joint declaration on CPD and LLL for health workers in the EU elaborated by the “drafting committee”
- Information on the good practice examples collected and to be included in the annex
- Discussion with HOSPEEM and EPSU members
- Agreement on next steps

Tjitte Alkema made some introductory remarks on the procedure to elaborate the joint declaration, its objectives and its intended use and explained that HOSPEEM had worked on a revised version of the document. He then highlighted the shift in the way training is taking place and referred to the “70-20-10 model”, suggesting that 70% of training of the health staff nowadays takes place at the workplace, 20% in formal training settings outside the workplace and 10% in informal settings. He reaffirmed that training was an investment in the health staff and underlined that the commonly agreed objectives of high level of patient safety and a good quality of health care would “justify” the need to invest in CPD and LLL for all health workers. He shortly referred to a presentation given by Marjolein Schouten (Jeroen Bosch Hospital Den Bosch, The Netherlands) on behalf of the hospital sector social partners at a workshop organised by DG SANTE on 11 February 2016 in Brussels on the interfaces between patient safety and the contents of CPD and from which a few principles should be kept in mind.

For HOSPEEM the joint declaration should put/keep a strong focus on the need to stimulate and sustain an involvement of health workers in CPD and LLL and on the responsibility of workers to participate in CPD and LLL that often can no longer be considered as “voluntary”, not least due to the needs of and the “innovation” in the health sector and health labour market and for the sake of patient safety and quality of care. Tjitte Alkema stated that financing and making CPD available was the core responsibility of employers. He underlined that it was different for LLL, where it is in principle the responsibility of the individual worker to participate in LLL, and therefore stressed the need to make a clear distinction between CPD and LLL in the document.

Looking at the planned joint declaration on CPD and LLL for all health workers in the EU, EPSU came up with several points discussed and agreed in the trade union preparatory meeting. They refer to changes in a version of the draft joint declaration on CPD and LLL proposed by HOSPEEM in February 2016 compared to the version presented at the SSDC HS Plenary meeting on 10 December 2015. The points raised are listed below:

- In the “Statement of principles” under the heading “Core business” the term “upskilling” was replaced by “upgrading”. Colleagues thought this could also mean a retrograde change, replacing better qualified workers by lower qualified workers. [The revised version 02/2016 suggested by HOSPEEM reads: “Patient care should be evidence-based in line with the most up to date research and good practice, and therefore requires constant upgrading of the workforce”].
- Under the same heading of the document, “practice” was changed into “functioning” [The revised version 02/2016 suggested by HOSPEEM reads: “CPD should ... form part of a learning environment in which staff give and receive feedback on performance and reflect, individually and collectively, on their functioning”]
- In the “Introduction” under the heading “Role of social partners”, the bullet point “Negotiating workplace and sectoral agreements” was removed
- In the same section of the document, a bullet point dealing with the “participation of workforce representatives” was removed. [The version 12/2015 reads: “Ensuring health staff have access to support in the workplace for example through learning representatives”]
Regarding bullet point 1 it was agreed that the two Secretariats and (in particular the English native speakers) members of the joint WG should again look into the terms “upskilling” and “upgrading”. Some colleagues said they could not see any difference between the terms. It was suggested that the term “upgrading” could also have been included in the revised version of the document simply to avoid the same word from being used twice in one sentence. It was suggested to mention both terms in the joint declaration. The final decision would be taken based on a proposal of the English native speakers in the joint CPD/LLL working group. The same goes for the rewording mentioned under bullet point 2. Colleagues from the HOSPEEM delegation said that the sentence mentioned under bullet point 3 should not have been deleted and could be put back into the document. It was also agreed that the members of the WG CPD/LLL should re-discuss and come up with a proposal for the final wording of bullet point 4.

EPSU colleagues also pointed out the key importance of the “employers’ responsibility”. If employers don’t organise or enable training possibilities in the sufficient quantity and quality, workers might in turn also lack motivation to engage in CPD. It was underlined that a more precise joint “understanding” of the concept “employers’ responsibility” should be aimed at and if possible be included in the document and that further clarity was needed with regard to “joint responsibility”. Helga Pile (Unison, UK) stated that the prime responsibility for the access to CPD was on the employer. Guy Crijns, CSC Services Publics (Belgium) underlined that in the current form his and other Belgian trade unions could not accept parts of the documents or even the whole document. Before concluding the discussion, EPSU colleagues also referred to “real life” barriers to access to CPD, e.g. due to staff shortages or high workloads.

Mathias Maucher said that the relative underrepresentation of groups of staff doing the “frontline/bedside care” when looking to those workers/health professionals having access and actually involved in CPD courses/programmes should be more highlighted in the joint declaration.

Not least in order to take advantage of the currently strong interest of social partners in a number of EU MS to do something tangible around CPD/LLL and to use the political momentum at EU-level and parallel initiatives by DG SANTE and other relevant stakeholders, it was agreed that an agreement on the joint declaration should be concluded during the meeting of WG 2/2016 SSDC HS on 2 June 2016.

It was also decided that controversial points on which no agreement would eventually be found would be taken out of the joint declaration.

A revised version of the document will be worked on first by the EPSU and HOSPEEM Secretariats and by members of the joint working group and shared by the end of April/early May 2016 with all HOSPEEM members and EPSU affiliates.

It was reaffirmed that the annex to the joint declaration should include a number of existing good practice examples that would also illustrate the different aspects covered by the text of the declaration. Mathias Maucher invited members to share examples they would consider as instructive for other HOSPEEM and EPSU members, ideally following the structure of a template prepared by the two Secretariats in order to make the annex more accessible. He went through the list of already presented or submitted examples from D, FIN, GB, N and NL to illustrate the broad range of aspects relevant for the development of CPD policies/programmes, etc. The members of the joint working group will – in addition to the general revisions of the document – be involved in the final selection of examples to be included in the annex.