



## Promoting effective recruitment and retention policies for health workers in the EU by ensuring access to CPD and healthy and safe workplaces supportive of patient safety and quality care (2017-2018)

**Report of the Social Partners' Conference on Continuing Professional Development. *"Working together, learning together – Switching to the learning mode"*. Amsterdam – 19 and 20 June 2017**



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# Acknowledgements

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# 1. Introduction

On 19 and 20 June 2017, HOSPEEM and EPSU – with the support of the Dutch HOSPEEM member Nederlandse Vereniging van Ziekenhuizen (NVZ) – organised the conference *“Working together, learning together – Switching to the learning mode”* in Amsterdam to deepen their thematic focus on Continuing Professional Development (CPD) and Life-Long Learning (LLL).

The event built on the HOSPEEM-EPSU Joint Declaration on Continuing Professional Development and Life-Long Learning for All Health Workers in the EU adopted in November 2016. In this document, the sectoral social partners in the hospital and healthcare sector recognise CPD as paramount for the maintenance and improvement of the quality of care and patient safety. Access to CPD and career options are presented as supportive of effective recruitment and retention policies. The joint declaration highlights that CPD and LLL initiatives should be considered as a long-term investment in the (productivity of the) health workforce and not as a cost factor. Social partners have a major role to play when it comes to CPD, in partnership with competent authorities and other relevant stakeholders. The declaration also states that undertaking CPD is a shared responsibility of employers and workers and depends to a large extent on the intrinsic motivation of employees to invest in their own development. HOSPEEM and EPSU finally recall the importance of taking local specificities into consideration and respecting the different national legal and regulatory frameworks when designing CPD systems.



The conference provided a forum for exchange and debate on a number of social partner-based initiatives presented by representatives of HOSPEEM members and EPSU affiliates from Belgium, Denmark, Finland, France, Germany, the Netherlands, Sweden and the United Kingdom and on the key role played by social partners in this field. It offered the opportunity to learn more about supportive regulatory frameworks for CPD and about policy measures aimed at facilitating access to CPD, updating or upgrading qualifications, skills, competence and professional practice, the provision of quality services by a hospital/healthcare workforce fit for practice and at a high level of patient safety. In addition, several researchers and government representatives shared their insights and experiences during the plenary sessions or during one of the four thematic breakout sessions organised.

A range of aspects related to CPD was covered by the presentations and discussions at the HOSPEEM-EPSU conference. These include: How to ensure sustainable models of financing of CPD for all types of health workers? How to make CPD available for all health workers equally irrespective of age, occupation, working pattern and type of contract? What can social partners at the different levels do to give better access to groups often under-represented in CPD and LLL, such as health workers aged 45+, part-time workers or workers with lower formal qualifications (mainly healthcare support staff)? Which models of CPD to use to support increasing demands of working in teams bringing together different health professions? How to best organise CPD on the backdrop of an increasing digitalisation of healthcare services (e-health; m-health; telemedicine)? How to build CPD as a key element of team and personal development planning and organisational development strategies? How to develop a partnership approach to designing, organising, implementing and assessing CPD policies and tools at national, sectoral and enterprise level?

Looking at the health professions, during the conference particular focus was given to nurses, healthcare support staff and doctors. This was also underpinned by four short testimonial videos of Dutch nurses about how they have benefited from CPD in their professional career and various work contexts so far and which expectations they have as to the organisation of CPD in the future. These videos can be watched on both the [HOSPEEM](#) and the [EPSU](#) websites.

During the conference, participants were asked to write down and share the most relevant “take-home messages”. The chairpersons, moderators and the closing panel used this input for the plenary discussions. The complete overview of all post-it-messages is presented in Chapter 3 of this report.

The report drafted from this conference is one of the deliverables of the project. It will be disseminated at national and at EU level and will feed into the future work of the Sectoral Social Dialogue Committee for the Hospital Sector on CPD. Another deliverable is the setting up of dedicated web pages on both the [HOSPEEM](#) and [EPSU](#) websites containing European and country-specific documents related to CPD and giving access to the complete set of presentations given at both conferences organised in the context of this project.

This conference was a key step for the sectoral social partners in the hospital and healthcare sector, HOSPEEM and EPSU, in identifying successful approaches, instruments and formats of CPD, both from the management and workers’ perspective. It brought together more than 100 participants from 18 EU Member States and four non-EU countries, including 35 participants from the Netherlands.

## 2. The Amsterdam CPD Conference

The conference was opened by a group interview involving Bas van den Dungen (Director General of the Dutch Ministry of Health), Elise Merlijn (FNV, The Netherlands) and Kate Ling (NHS, United Kingdom). The social partner representatives highlighted some of the trade unions' and employers' priorities in the field of CPD and LLL, the key opportunities and problems to be addressed. The participants watched a [video message](#) by Commissioner Andriukaitis in which he expressed his support for the Joint HOSPEEM-EPSU Declaration on CPD and LLL for all Health Workers in the EU and for the ongoing work of the sectoral social partners in the hospital sector in the field of CPD.

On the basis of the varying expertise and background of the speakers, five common grounds could be identified. These so-called 'themes' are presented in the five paragraphs below.

### 2.1. Theme 1: The need for CPD

Several speakers underlined the urgent need for CPD and LLL. Firstly, because as in more and more EU countries the age of effective retirement has gone up and workload and work intensity are increasing, a growing share of the healthcare staff is considering leaving their job. Furthermore, the average age of patients and their need for more complex care are also rising (Oerlemans), leading to a higher demand for more and better-trained staff. The same holds true for shifts in required nursing specialisms (Steenberg and Lund), introduction of new types of healthcare, a stronger focus on



home care, the rapid introduction of ICT, increasing patients' demands, they, in particular, ask for more control over their treatment and want to be better informed (Towle and Casagrande), combined with a tightening of the budget (Alkema, Van Dungen, Merkel). These factors can contribute to a downward spiral resulting in a shortage of adequately trained nurses (Beck and König). In combination with inadequate career possibilities, it can become difficult to retain highly trained and experienced nurses of 40 years and older, potentially leading to a knowledge drain (Stalpers and Vermeulen, Andriukaitis) and consequently extra costs for the employer and society. There is also a link with quality of care: based on data from the Special Eurobarometer Balazs Lengyel stated that 'well-trained medical staff is the most important element of high-quality healthcare'.

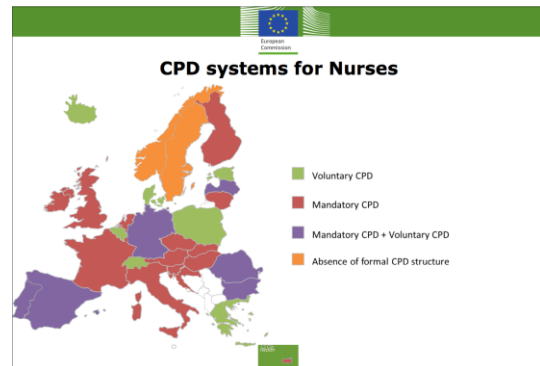
All these developments underpin that CPD and LLL are paramount for the quality of care, patient safety and staff safety. Data drawn from the UNISON's (UK) 2016 survey show that a need for CPD can also be felt by the staff themselves: 61% of 2,300 included clinical support workers rate the development opportunities they get as 'inadequate'. Speakers Pile and Donohue stated that health care assistants 'want to be educated, recognised and supported'.

This need is not only felt by the workers, it's also supported by the Directive 2005/36/EC, revised by Directive 2013/55/EU (Lengyel), which states that 'Member States are required to ensure that professionals are able to update their knowledge, skills and competencies'.

## 2.2. Theme 2: How can CPD be effective?

Looking for the most effective way of organising CPD we have to realise that in Europe there is a 'wide range of national approaches and mechanisms, diverse across the professions' and that there is 'no best method of learning to ensure better patient safety and quality of care' (Lengyel)<sup>1</sup>. Still, some common grounds could be identified during the conference.

Firstly, the current credit-collecting framework seems to limit the effectiveness of CPD. Grant stated that there is no rationale for any kind of awards or credits to stimulate effectiveness. 'Credit recognition systems do not recognise actual effective ways of learning. If you give people a credit-based incentive, people behave in an undesirable manner. Learning is a process, not an event' (Grant).



Secondly, speakers agreed that training could only be effective when it also meets the individual needs of the worker. In that case, it is relevant to the individual in his or her own context. Therefore, individual learning needs and competencies should be assessed in order to facilitate tailored education (Van Dungen, Beck and König). Landman and Wahab presented an online self-assessment tool giving insight in (missing) competencies, ambitions and career pathways. Additionally, their hospital (North West Hospital, NL) uses the annual appraisals for tailoring the CPD to the individual needs of the worker. During these appraisals managers discuss the personal development and education plan with the employee.

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<sup>1</sup> Source: EAHC/2013/Health/07. Study concerning the review and mapping of continuous professional development and lifelong learning for health professionals in the EU.



Thirdly skills level differentiation should be considered when enhancing CPD effectiveness. It can be helpful in providing an educational environment in which all nurses excel on their own level, including the academic level (Stalpers and Vermeulen, Steenberg-Holtzmann and Lund).

Fourthly, experiments with new, creative ways of learning must be encouraged. The following examples from The Netherlands are taken from break-out session 4. For example, Overeem presented the concept of 'Crew Resource Management' as an example of building healthcare teams while focusing on effective communication and leadership. Learning from scenarios in a team with video feedback and debriefing has turned out to be very beneficial and effective. Additionally, De Jong and Verwoert presented the 'Escape Room' as a new creative way of training. An escape room is a game where one gets locked up with a team. The target is to escape from the room within 30 minutes. For this, they have to solve puzzles, riddles and mysteries relevant to their learning needs and competencies. If the group succeeds, they will find a code to regain their freedom. The escape room is a team effort. The team has to think critically, creative and logical and also needs to collaborate, communicate and show leadership under time pressure. To increase the learning effectiveness the escape room experience is followed by a 30-minute debriefing, led by a trainer.



*Active learning in an escape room (Spaarne Hospital, NL).*

Finally, based on the – during the conference often mentioned – rule of thumb that learning happens for 70% at the workplace, for 20% when exchanging information with colleagues and for 10% in a formal, explicit learning context, Oerlemans, but also Johansson and Cider, advocated that learning should be done more 'in the work place'. In line with this 'on the job' and 'at the moment of need' training Van der Worp presented the concept of EPSS (Embedded Performance Support System) which is a Dutch database of instructional videos nurses can view on their mobile phone or on a desktop computer whenever or wherever they need instruction.



## 2.3. Theme 3: Participation (workers and patients)

The third common ground found in several contributions was explicitly using patients' input in the training provided. Towle and Casagrande stated that patients should play an active and collaborative educational role as teachers, assessors, curriculum developers and educational decision makers: training *with* the patients. This is relevant for the entire continuing professional development, not just for only the initial training. Patient participation is said to enhance communication and emphatic and caring relationships and promote patient safety and quality improvement.



This concept of ‘patient empowerment’ is also incorporated in the Danish BRIDGE model where hospitals and communities work together and patients participate in educational activities, both as teachers and as participants (Steenberg-Holtzmann and Lund).

## 2.4. Theme 4: Cooperation between social partners and funding of CPD

Cooperation between social partners is also an important theme that was highlighted in several presentations. In the view of Pile workers and employers both are critical stakeholders and critical friends: ‘social partnership will help overcome the challenges regarding the implementation of CPD’. In line with this Beck and König stated that CPD should always be part of the social bargaining. In break-out session 3, it was explained that for example in Bulgaria social partners jointly plan and decide on the design of CPD, and CPD is considered part of an improvement process of the quality of healthcare. Also in Montenegro trade unions need to agree on plans for CPD and have a say in their evaluation, according to national legislation. Johansson and Cider presented an arrangement between social partners and education providers in Sweden regarding quality certification for training, a cooperation of key actors at local and regional levels and a focus on ‘on the job’ training. Steenberg-Holtzmann and Lund considered the full involvement of the social partners as an important success factor for their Danish BRIDGE model where hospitals and communities work together improving CPD.



When it comes to financing CPD Oerlemans presented the Dutch Collective Labour Agreement for Hospitals (2015) stating that non-mandatory CPD and LLL learning is a

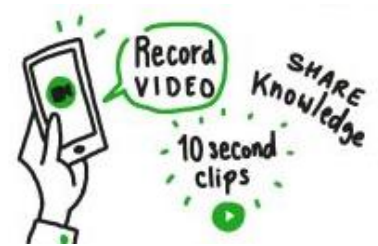


right for all employees and this 'right for all' is funded with an earmarked budget of 3% of the average wage-budget per hospital.

Lefebvre shared the Belgian experience with regard to the dialogue and negotiations between social partners on the annual budgets for CPD. In Belgium funding for CPD partly comes from workers (0.1% of their salary). It is put into a dedicated CPD fund according to the decisions of the social partners, consequently being the subject of bargaining. The larger share for CPD comes from the government and the main accountability in this field stays in the hands of each hospital. For the French-speaking part of Belgium, the paritarian organisation 'Competentia' was established by the social partners to support health and social care institutions in implementing CPD. Flanders operates in a similar way.

In Croatia nurses often need to fund their CPD themselves. There is a need for cooperation between social partners to implement a joint action plan on issues such as design of CPD, funding, underrepresented groups and conditions to access CPD.

In Latvia as a rule, health workers have to fund their own CPD, even though some training and education is compulsory. Sometimes, mainly for doctors, funding of CPD comes from pharmaceutical enterprises. An example of commercial support can be found in the Netherlands where the Green Heart Hospital and a publisher co-created EPSS (an online database with instructional videos).



## 2.5. Theme 5: What competencies do we need?

The answer to the question 'what competencies do we need?' is more or less given in paragraph 2.2 of this report. As education can only be effective when it also meets the individual needs of the worker, the required competencies – building on initial vocational training and education (VET) and the work experience during the professional career – are also highly individual and should be assessed accordingly.

On the one hand, generally spoken Stalpers and Vermeulen underline the importance of clinical academic career pathways in order to prevent losing highly educated staff ('brain drain'). On the other hand, there is the risk of educating too much academically trained nurses as the vast majority of caregivers is needed for hands-on nursing at the bedside.

Associated with this the concept of horizontal career development is interesting (Beck and König). Here the focus is not so much on a vertical career path (management jobs, striving for an academic level, etc.) but more on developing specialised skills and knowledge within the present job and/or profession (wound care nurse, ErgoCoach, etc.).



From their Danish experience, Steenberg-Holtzmann and Lund presented competencies that are relevant to the new era in healthcare: interdisciplinary and interprofessional competencies, competencies in relation to patient and family involvement, technical and

ICT competencies, communicative competencies and competencies to create seamless care between primary and secondary care provision.

## 2.6. Theme 6: Underrepresented groups

One of the cornerstones of the HOSPEEM-EPSU Joint Declaration is that CPD has to be available for everyone and for all forms of contracts. Moreover, the focus should be on underrepresented groups in training. Merkel mentioned the older workers as an underrepresented group and CPD can help them to cope with new technical, organisational and ICT developments. A stronger focus on CPD for older workers should avoid the risk of age discrimination and exclusion from career opportunities.

Another example of an underrepresented group in CPD is health care support staff. Pile and Donohue stated that *'many care assistants want to remain in their role but some want to progress – opportunity to earn and learn would allow this'* and also *'that care assistants want their role valued – they want to be educated, recognised and supported'*. Pile and Donohue presented the 'nursing associate' (Level 5 apprenticeship with a foundation degree required) as a new career opportunity in nursing. This new role seeks to develop an untapped potential and achieve a workforce drawn from a wider cross-section of local communities.

In general Landman and Wahab mentioned employees working in intensive care, emergency care, operating rooms and cardiology units as underrepresented in CPD. In order to make CPD available for all, they developed the Roadmap as a support for CPD, connecting the ambitions of the organisation with its employees. With this tool, employees can investigate their own career opportunities by comparing their current job with a potential job.

### 3. Take-home messages

Based on the speakers' presentations, the plenary discussions, the presented videos, the post-it's on the message wall and the concluding remarks of the closing panel<sup>2</sup> the following 'take-home messages' can be formulated:

- As CPD is an asset, not a cost, budget restraints cannot be an excuse not to explore models for sustainable funding of CPD.
- Fund CPD with an earmarked, protected budget (e.g. as a percentage of the average wage budget per hospital or using special funds) to make sure CPD does not depend on economic fluctuations.
- Commercial support can be helpful in developing new ways of CPD.
- When CPD takes the form of training organised away from the workplace, provisions have to be made for replacement, limiting the additional burden for the staff.
- There is no rationale for accreditation. Not only the outcome but also the learning process (plan and reflection) should be recognised as credits.
- It is essential to link training also to the individual needs of workers. For the best result learning has to be custom made.
- Do not only invest in vertical careers. In healthcare, there are opportunities for horizontal careers.
- Value not only professional formal training but informal learning as well. Focus on training 'on the job'.
- Have an open mind for new, creative ways of CPD.
- Involving patients ('patient empowerment') can be a success factor for CPD.
- Clinical academic career pathways are important to prevent 'brain drain'. At the same time, there is the risk of educating too much academically trained nurses where the vast majority of the nurses are needed for practical (nurse-) work at the bedside.
- A stronger focus on CPD for older workers should avoid the risk of age discrimination and exclusion from career opportunities.
- Create awareness that initial and post-initial training should be seen as a continuum to support continuing professional development.



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<sup>2</sup> Sabine Scheer (NVZ, The Netherlands), Kirsi Sillanpää (Tehy, Finland - Vice-President EPSU SC HSS) and Alice Casagrande (FEHAP, France) moderated by Nico Knibbe (LOCOmotion, The Netherlands).

## 4. Summary to move forward

Building on the HOSPEEM-EPSU Joint Declaration on Continuing Professional Development and Life-Long Learning for All Health Workers in the EU on 19 and 20 June 2017, HOSPEEM and EPSU – with the support of the Dutch HOSPEEM member Nederlandse Vereniging van Ziekenhuizen (NVZ) – organised the conference “Working together, learning together – Switching to the learning mode” in Amsterdam. HOSPEEM and EPSU pursued the objective to deepen their thematic focus on Continuing Professional Development (CPD) and Life-Long Learning (LLL).

This conference was a key step for the sectoral social partners in the hospital and healthcare sector, HOSPEEM and EPSU, in identifying successful approaches, instruments and formats of CPD, both from the management and workers’ perspective.

The presentations and discussions at the conference underpinned the urgent need for CPD and LLL, because as in more and more EU countries the age for effective retirement has gone up a growing share of the health staff is considering leaving their job as a result of this effort, new concepts of health care and ICT are introduced, there is a stronger focus on home care, and patients’ demands are increasing. Without adequate CPD these factors can lead to a downward spiral resulting in a shortage of nurses, a decreased quality of care and increased costs for the employer and society.

Speakers agreed that training could only be effective when it also meets the individual needs of the worker. Therefore, based on skills level differentiation, individual learning needs and competencies should be assessed in order to facilitate tailored education. Experiments with new, creative ways of learning should be welcomed and encouraged while keeping in mind that learning on the job is where most of the learning happens. Also, patients’ input in the training (‘patient empowerment’) is considered to be a success factor.

Cooperation between social partners is necessary to overcome the challenges regarding the implementation of CPD. Several inspiring examples from the different EU Member States were presented, also when it comes to funding.

# Appendix 1: Agenda, speakers and topics of the conference

## Monday 19 June 2017

12.00 – 13.45      *Registration (next to the plenary room – Calla 3)*

12.30 – 13.30      *Welcome lunch*

Chair: Maryvonne Nicolle (CFDT Santé Services Sociaux, France/Vice-President EPSU SC HSS)

14.00 – 14.45      - Welcome by Tjitte Alkema (NVZ, The Netherlands/Secretary General of HOSPEEM)  
- Introduction by Mr. Bas van den Dungen (Director General VWS, Ministry of Health, The Netherlands)  
- Group interview moderated by Nico Knibbe:

- Mr. Bas van den Dungen
- Elise Merlijn (FNV Zorg en Welzijn, The Netherlands)
- Kate Ling (NHS, UK)

- Video address from Commissioner for Health and Food Safety Vytenis Andriukaitis, DG SANTE

14.45 – 15.30      **Working and learning in the service**  
**Managing continuing professional development**  
*Prof. Janet Grant (CenMEDIC, UK)*

15.30 – 16.00      *Tea/coffee break*

16.00 – 16.35      **Heidelberg Expertise for a continuing professional advancement**  
*Herbert Beck (ver.di, Germany), Edgar Reisch (University Hospital Heidelberg, Germany) and Anja König (University Hospital Heidelberg, Germany)*

16.35 – 17.10      **A nurse is a nurse is a nurse? Skills level differentiation in the Netherlands**  
*Prof. Hester Vermeulen (Radboud University Medical Center, The Netherlands) and Dewi Stalpers (NVZ, The Netherlands)*

17.10 – 17.45      **CPD for support staff: a new career opportunity in nursing**  
*Helga Pile (UNISON, UK) and Sam Donohue (Health Education England, UK)*

## **Tuesday 20 June 2017**

08.30 – 09.00      *Welcome coffee*

Chair: Tjitte Alkema (NVZ, The Netherlands/Secretary General of HOSPEEM)

09.00 – 09.45      **Introducing the contribution of patients and/or social care users in the training process**  
*Dr. Angela Towle (University of British Columbia, Canada) and Alice Casagrande (FEHAP, France)*

09.45 – 10.30      **DG SANTE study “Mapping CPD and LLL for health professionals in the EU”**  
*Balazs Lengyel (DG SANTE, European Commission)*

10.30 – 11.00      *Tea/coffee break*

11.00 – 12.30      4 break-out sessions:



**Different angles to effective CPD (in plenary room – Calla 3)**

Chair: Herbert Beck (ver.di, Germany)

- **Definition of CPD priorities and negotiations of professional branches on CPD activities/programmes in the French hospital sector**

*CFDT video and intervention of Cyrille Duch (CFDT Santé Services Sociaux, France)*

- **Competence development of an ageing workforce in German hospitals**

*Dr. Sebastian Merkel (IAT, Gelsenkirchen, Germany)*

- **How to cooperate between trade unions, employers and education providers in setting up effective CPD in Sweden?**

*Margaretha Johansson (Kommunal, Sweden) and Zenita Cider (CEO of health and care services college, Sweden)*

Languages: English, French, German and Dutch



**Inter-professional cooperation and skills development (Room Rosa 4)**

Chair: Kirsi Sillanpää (Tehy, Finland/vice president EPSU SC



HSS)

**- The BRIDGE model – A competency development programme designed to enhance interprofessional collaboration, shared knowledge and patient and citizen involvement across sectors.**

*Jette Steenberg Holtzman and Winnie Lund (Center for human resources, Capital Region of Denmark)*

**- How does CPD support multi-professional team-based care? An example from Finland**

*Juhapetteri Jääskeläinen (Deputy Nurse Manager, Helsinki University Central Hospital HUCH, Helsinki Burn Centre, Finland)*

Language: English

**3**

**Funding of CPD (Room Rosa 5)**

Chair: Frank Tettersoo (NVZ, The Netherlands)

**- How is, or should, CPD be financed? An example from the Netherlands**

*Niels Oerlemans (NVZ, The Netherlands)*

**- Competentia – Roles and activities of a paritarian organisation to promote and support CPD for care workers**

*François-Xavier Lefebvre (Competentia, Belgium)*

Language: English

**4**

**Innovative work-place learning (Room Rosa 6)**

Chair: Sabine Scheer (NVZ, The Netherlands)

**- Crew Resource Management: a Dutch example of building health care teams focusing on effective communication and leadership**

*Erica Overeem (Gelre Hospital, The Netherlands)*

**- Good practice: Short video instructions at the moment of need**

*Jaco van der Worp (Groene Hart Hospital, Gouda, The Netherlands)*

**- Learn to escape!**

*Cuun de Jong and Priscilla Verwoert (Spaarne guesthouse, The Netherlands)*

Language: English

12.30 - 13.45

*Lunch break*

Chair: Tjitte Alkema (NVZ, The Netherlands/Secretary General of HOSPEEM)

13.45 - 14.30

Reporting back from the break-out sessions: Presentation of the main outcomes from the presentations and discussions.

**Break-out session 1: Different angles to effective CPD**

Rapporteur: Nina Bergman (Vårdförbundet, Sweden)

**Break-out session 2: Inter-professional cooperation and skills development**

Rapporteur: Malene Vestergaard Sørensen (Danish Regions, Denmark)

**Break-out session 3: Funding of CPD**

Rapporteur: Juha Kurtti (Tehy, Finland)

**Break-out session 4: Innovative work-place learning**

Rapporteur: Taija Hämäläinen (CLAE, Finland)

- 14.30 - 15.00      **The 'Roadmap': A Dutch example of organising support for Continuous Professional Development that fits within the ambitions of the organisation and its employees**  
*Harm Landman and Hannah Wahab (Noordwest Ziekenhuisgroep/North West Hospital Group, Alkmaar, The Netherlands)*
- 15.00 - 15.15      *Short break*
- 15.15 - 16.00      Closing panel/Wrap up session moderated by Nico Knibbe: Presentation of take-home-messages and cartoons and discussing these with the conference participants.
- Sabine Scheer (NVZ, The Netherlands)
  - Kirsi Sillanpää (Tehy, Finland - Vice-President EPSU SC HSS)
  - Alice Casagrande (FEHAP, France)
- The panellists will also be asked to highlight a take-home-message and/or a cartoon.

## Appendix 2: Delegates, represented countries and their organisations

HOSPEEM	NVZ	Tjitte	Alkema	The Netherlands
EPSU	PA.SY.DY	Andronikos	Andronikou	Cyprus
EPSU	PA.SY.DY	Zoe	Antoniou	Cyprus
PSI	PSI	Baba	Aye	France
HOSPEEM	HOSPEEM Secretariat	Céline	Barlet	Belgium
EPSU	Ver.di	Herbert	Beck	Germany
EPSU	EPSU Secretariat	Sarrah	Bentahar	Belgium
HOSPEEM	Spekter	Trond	Bergene	Norway
EPSU	Vårdförbundet	Nina	Bergman	Sweden
EPSU	HSSMS-MT	Marija	Berislavic	Croatia
HOSPEEM	ARAN	Marta	Branca	Italy
EPSU	Trade union of health and social care of Czech Republic	Ivana	Břeňková	Czech Republic
Other	Dutch Ministry of Health	Gert	Buisman	The Netherlands
HOSPEEM	FEHAP	Alice	Casagrande	France
HOSPEEM	Kempenhaeghe - NVZ	Marlene	Chatrou	The Netherlands
Other	VO-Health and Care Services College	Zenita	Cider	Sweden
EPSU	NNO	Tore	Dahlstrøm	Norway
HOSPEEM	NVZ	Jeannette	De Graauw	The Netherlands
Other	Spaarne Gasthuis	Helene	De Groot	The Netherlands
Other	Sophia Revalidatie	Mascha	De Haan	The Netherlands
Other	Spaarne Gasthuis	Cuun	De Jong	The Netherlands
EPSU	NU'91	Rolf	De Wilde	The Netherlands

HOSPEEM	HSE	John	Delamere	Ireland
EPSU	CGSP-ACOD	Muriel	Di Martinelli	Belgium
Other	StAZ	Mieke	Dinjens	The Netherlands
Other	Health Education England	Samantha	Donohue	United Kingdom
EPSU	CFDT Santé Sociaux	Cyrille	Duch	France
EPSU	SPS-FO	André	Falba	France
HOSPEEM	HOSPEEM Secretariat	Sara	Fasoli	Belgium
Other	Stichting ZorgSaam Zorggroep Zeeuws-Vlaanderen	Beatrice	Fest	The Netherlands
EPSU	SIPTU	Kevin	Figgis	Ireland
EPSU	CNE (CSC)	Marie-Agnès	Gilot	France
Other	CenMEDIC	Janet	Grant	United Kingdom
EPSU	Kommunal	Yvonne	Gräsman	Sweden
HOSPEEM	Lithuanian national association of health care organizations	Sigitas	Griskonis	Lithuania
HOSPEEM	National Union of Private Hospitals	Krasimir Dimitrov	Grudev	Bulgaria
Other	StAZ	Femke	Haenen	The Netherlands
EPSU	EPSU	Julian	Hale	Belgium
HOSPEEM	CLAE	Taija	Hämäläinen	Finland
EPSU	NUMGE	Signe	Hananger	Norway
HOSPEEM	Spekter	Björn	Henriksen	Norway
Other	Groene Hart Ziekenhuis	Conny	Hes	The Netherlands
EPSU	Ver.di	Marek	Hintsches	Germany
Other	Helsinki University Central Hospital HUCH, Helsinki Burn Centre	Juhapetteri	Jaaskelainen	Finland

EPSU	Kommunal	Margaretha	Johansson	Sweden
EPSU	LSADPS	Dalia	Juskeviciene	Lithuania
EPSU	The Finnish Union of Practical Nurses	Leena	Kaasinen	Finland
HOSPEEM	Latvian Hospital Association	Jevgenijs	Kalejs	Latvia
HOSPEEM	CLAE	Johanna	Karlström	Finland
Other	Westfriesgasthuis	Pieter	Kievit	The Netherlands
EPSU	Vida	Valérie	Kihr	Austria
Other	LOCOmotion	Nico	Knibbe	The Netherlands
EPSU	FTU – HS	Ivan	Kokalov	Bulgaria
HOSPEEM	Estonian Hospitals Association	Märt	Kõlli	Estonia
Other	Akademie für Gesundheitsberufe Universitätsklinik Heidelberg	Anja	König	Germany
EPSU	Tehy	Juha	Kurtti	Finland
Other	North West Hospital Group	Harm	Landman	The Netherlands
EPSU	APEF asbl	François-Xavier	Lefebvre	Belgium
EPSU	JHL	Veikko	Lehtonen	Finland
Other	European Commission – DG SANTE	Balazs	Lengyel	Belgium
HOSPEEM	NHS	Kate	Ling	United Kingdom
EPSU	OSZSP ČR	Francl	Lubomir	Czech Republic
Other	The Capital Region of Denmark, Centre for Human Resources	Winnie	Lund	Denmark
Other	Visuality	Christopher	Malapitan	Belgium
EPSU	EPSU Secretariat	Mathias	Maucher	Belgium
Other	Institut für Arbeit und Technik (IAB)	Sebastian	Merkel	Germany
EPSU	FNV Zorg en Welzijn	Elise	Merlijn	Netherlands
Other	StAZ	Niels	Mooij	The Netherlands

Other	StAZ	Hedwig	Neefs	The Netherlands
EPSU	CFDT Santé Sociaux	Maryvonne	Nicolle	France
EPSU	The Finnish Union of Practical Nurses	Arja	Niittynen	Finland
HOSPEEM	NVZ	Niels	Oerlemans	The Netherlands
Other	Gelre Hospitals	Erica	Overeem	The Netherlands
EPSU	TUPHWB	Hanna	Padrez	Belarus
EPSU	Sindikato Zdravstva Crne Gore (SZCG)	Vladimir	Pavicevic	Montenegro
EPSU	UNISON	Helga	Pile	United Kingdom
EPSU	YOUNION	Karl	Preterebner	Austria
EPSU	LSADPS	Brigita	Rasimaite	Lithuania
Other	Universitätsklinik Heidelberg	Edgar	Reisch	Germany
HOSPEEM	NVZ	Sabine	Scheer	The Netherlands
EPSU	Ver.di	Brigitte	Schero	Germany
EPSU	Ver.di	Rudolf	Schoen	Germany
EPSU	FNV Zorg en Welzijn	Jan	Schriefer	The Netherlands
EPSU	Tehy	Kirsi	Sillanpää	Finland
EPSU	RCM	Jonathan	Skewes	UK
HOSPEEM	HOSPEEM Secretariat	Emilie	Sourdoire	Belgium
HOSPEEM	NVZ	Dewi	Stalpers	The Netherlands
Other	The Capital Region of Denmark, Centre for Human Resources	Jette	Steenberg Holtzmann	Denmark
EPSU	Vida	Willibald	Steinkellner	Austria
HOSPEEM	NVZ	Frank	Tetteroo	The Netherlands



HOSPEEM	NFU	Monica	Teuns	The Netherlands
HOSPEEM	FEHAP	Laetitia	Tibourtine	France
Other	University of British Columbia	Angela	Towle	Canada
EPSU	NUMGE	Raymond	Turoy	Norway
Other	Dutch Ministry of Health	Bas	Van den Dungen	The Netherlands
Other	Groene Hart Hospital, Gouda	Jacco	Van der Worp	The Netherlands
HOSPEEM	NVZ	Marileen	Van Horne	The Netherlands
Other	Bernhoven B.V.	S.	Van Roosmalen	The Netherlands
Other	Noordwest Ziekenhuisgroep Alkmaar	E.	Van Soelen	The Netherlands
Other	CNV	Joost	Veldt	The Netherlands
HOSPEEM	IQ healthcare Radboudumc	Hester	Vermeulen	The Netherlands
Other	Spaarne Gasthuis	Priscilla	Verwoert	The Netherlands
HOSPEEM	Danish Regions	Malene	Vestergaard Sørensen	Denmark
Other	Spaarne Gasthuis	Marianne	Voskamp	The Netherlands
Other	North West Hospital Group	Hanna	Wahab	The Netherlands

## Appendix 3: Abstracts of the presentations

### **Working and learning in the service**

#### **Managing continuing professional development**

*Prof. Janet Grant (CenMEDIC, UK)*

This presentation will analyse the purposes of continuing professional development (CPD) and ask how we can design an approach that delivers all the intended benefits and recognises evidence about the effectiveness of learning at this level, as well as acknowledging the need for professional transparency and accountability. The current credit-collecting framework is limited in its effectiveness, and in its integration with both healthcare service and personal interests. Learning is a process, not an event. An approach to planning and recognising that process will be described, based on what is known about how doctors actually identify their learning needs, learn, and return that learning to practice. An example of such process in current practice will be given. Reference: Grant, Janet [2012] *The Good CPD Guide*. 2nd edition. Taylor and Francis, London.

### **‘A nurse is a nurse is a nurse?’ Skills level differentiation in the Netherlands**

*Prof. Hester Vermeulen (Radboud UMC, The Netherlands) and Dr. Dewi Stalpers (Dutch Hospital Association, The Netherlands)*

In this joined presentation, prof. Hester Vermeulen (Radboud UMC) and dr. Dewi Stalpers (Dutch Hospital Association) address the subject of nurses’ skills level differentiation in the Netherlands.

First, an overview of the Dutch health care workforce will be given in which it is shown that nurses are the largest group of health care professionals. Various national reports and international scientific studies emphasize the importance of adequate skill-mix in relation to the quality of nursing care. Topics such as good positioning of nurses with different competencies and educational levels and efficient deployment of staff are relevant in this context.

The most recent development in the Dutch health care system involving nurses, is the proposed amendment of law: from one level of registered nurses to two levels of nurses, namely Vocational level nurses (EQF 4) and Bachelor level nurses (EQF 6). To anticipate on this enormous transition of approximately 180.000 overall of which 80.000 nurses working in hospitals, the Quality Impulse Hospital Personnel (KiPZ) is made available by the Dutch Hospital Association in collaboration with the Ministry of Health, Welfare and Sports. From this subsidy, hospitals can invest in continuous professional development (CPD) of their staff, for example by E-Health and upgrading educational levels.

In the context of retention and retaining of the nursing workforce, it is necessary to look at the roles and opportunities for nurses of all kinds of educational levels, including Masters and PhDs. Therefore, clinical academic career pathways are important. Skills level differentiation in itself is not the goal, but it can be used as a mean to create efficient nursing teams, high performing organisations and optimal patient outcomes.

**Career pathways and opportunities for development into higher-skilled roles.**

*Helga Pile (UNISON, UK) and Sam Donohue (Health Education England, UK)*

This presentation will consider the CPD needs of healthcare support workers looking at the development in England of the nursing associate role, a new career opportunity in nursing. There is strong demand from support workers for professional development into higher-skilled roles. The nursing associate role seeks to develop this untapped potential and achieve a workforce drawn from a wider cross-section of local communities. The presenters will reflect on the experience of partnership working between government agency and trade unions, and will outline some of the issues emerging from the test site programme.

**Introducing the contribution of patients and / or social care users in the training process**

*Angela Towle (University of British Columbia, Canada)*

Drawing on personal experience at the University of British Columbia in Canada, personal involvement in international initiatives, and the literature, this presentation will address the following questions: what do we mean by patient involvement in CPD? Why involve patients and what are the benefits? What are some examples of patient involvement in CPD? The presentation will briefly describe a wide range of educational initiatives in which patients and service users can enhance CPD, and some lessons learned.

*Alice Casagrande (FEHAP, France)*

Believing in patient involvement in CPD is one thing, implementing it is another. After hearing about international initiatives and literature, this presentation will explain the way a small task force initiated by the Fehap with a series of partners tried to move from ideas – and ideals – to concrete realization. From the practical difficulties and various resistances and criticisms that the group encountered, a series of lessons can be learned, concerning the way to help patient and social care service users' expertise and knowledge be fully recognized by all parties.

### **Competence development of an aging workforce German hospitals.**

*Dr. Sebastian Merkel (IAT, Gelsenkirchen, Germany)*

Currently, the health and social care sector is facing multiple challenges: a rising demand for workers, a high share of older workers, challenging working conditions, the digitalization, to name a few. The demand for longer working careers has become widespread in modern societies, as growing life expectancy increases economic pressures for sustainable approaches to the work life participation of older employees. To deal with these challenges, age management offers promising measures. Within the European project EXTEND (Social inequalities in extending working lives of an ageing workforce) case studies are conducted in several organisations (hospitals, in-patient and out-patient care) in which such measures are analyzed.

### **Cross-sectoral development of skills and qualifications in Denmark – the BRO project.**

*Winnie Lund Jette and Steenberg Holtzman (Center for human resources, Capital Region of Denmark)*

#### *Background*

Patients and citizens are faced with challenges in relation to obtaining seamless care. The health care professionals have been educated in and often work in separate institutions and the organizational structures are not designed to overcome these challenges.

#### *Objectives*

Enhanced patient involvement, relational coordination and leadership engagement.  
Improved quality of care and creating seamless patient pathways for the elderly patients.

#### *Methods*

The target groups are health care professionals across primary and secondary settings. The BRIDGE model is a joint venture between a hospital and the communities of the uptake area. During 2013 – 2016 six processes have been established with the participation of six hospitals, 15 municipalities, 200 health care professionals, more than 100 leaders and over 50 users of the health service.

The BRIDGE model consists of several central activities. Local key stakeholders are identified and function as a planning committee. This committee engages with leadership teams to ensure engagement and involvement. A Kick Off is held followed by three education sessions of two - three days. The participants create a specific collaboration activity designed to enhance seamless care across the settings. This is followed by presentation for leaders and patients and lastly three knowledge seminars are held to ensure sustainability. This process takes 4 – 6 months.

#### *Results*

The BRIDGE model has been evaluated within the theoretical frame of Program Theory. The results show that participants have enhanced knowledge and actions regarding patient involvement, coordination and communication across primary and secondary sector. The relational coordination has increased and the participants have gained mutual respect, shared knowledge and shared objectives.

#### *Implications*

The BRIDGE model has been used within the somatic elderly patient pathways, but the results indicate that it can be transferred into other pathways characterized by complexity, a need for seamless care and multiple health care professionals.

#### **How does CPD support multi-professional team-based care? An example from Finland.**

*Juhapetteri Jääskeläinen (Master of Health Care, Deputy Nurse Manager, Helsinki Burn Center, Finland)*

Trauma is a leading death cause in western countries for working age people. EuroSafe estimates in their 2013 published report (Injuries in the European Union) that over 230 000 people die every year due to injuries sustained in accidents and violent acts. Also they estimate that approximately 5,7 million people are admitted to hospital and 33,9 million treated as hospital outpatients. Typical Finnish major trauma patient is middle aged man, who has been injured in traffic or work-related accident.

At the beginning of millennia Töölö hospital was in a new situation due to organizational changes. Patient flows were increasing as the resources were not. There is a lot of history in treating major trauma patients in Töölö hospital, but problems started to manifest in new situation. There was too much variation in practices and in quality of the treatment according to time of the day and month and according to who was on shift. This was deemed unacceptable and lot of practices were changed in aim to provide high quality treatment of trauma patients 24 / 7 / 365.

One of the projects was the implementation of the Traumaprotocol and Traumatteam. Traumatteam is a multi-professional team, that works simultaneously on different tasks in the vital resuscitation of the trauma patient in hospital emergency room. According to studies Traumatteam approach improves mortality and allows tasks to be completed in shorter time. In overall trauma teams all over the world have had a fundamental impact on trauma patients' outcomes. Traumaprotocol is the handbook for the team – it defines the roles of different members and how the patient is to be treated.

In Töölö hospital CPD is vital for fluent teamwork and it consists of several different parts. It has grown to be vital part of Töölö hospital culture and has taken several years to evolve and the work of many dedicated professionals.

All new staff are given personal orientation according to their former experience, this can take weeks, months or years. Nursing staff are given a personal mentor that helps

the novice nurse to accumulate needed information and skills. A lot of learning happened while doing day-to-day-work. The usually slow morning time in the ER is used to teach small-groups of nurses. This training covers for example systematic evaluation of the trauma patient (A B C D E), different procedures, non-technical skills, communication and multi-casualty-incidents.

Töölö hospital emergency room has training days twice a year and the aim is that all the personnel are able to participate in to them. These day contain lectures, small-group teachings and different kind of exercises. More advanced nurses and doctors take part in single- and multi-professional conferences. These have participants from all over Finland and usually contain lectures and different workshops. The most experienced nurses and doctors take part in national and international trauma courses like European Trauma Course.

The trauma team practices in full scale simulations that are organized monthly or more frequently. In these the whole team treats a simulated patient in realistic, real-life conditions. These practices are mandatory for all personnel before they are assigned to real trauma team atications. In simulations the team practices communication and other essential non-technical skills, but also different technical skills.

Good education and learning demands also feedback. This is provided in debriefing and trauma meetings. If possible, after the patient has been transferred from the ER the team regroups to have a debriefing about the case. The aim of the debriefing is to compare different perspectives about what was done: what was done right and what could've been done better. Also this is a good way to resolve issues if there were any conflicts between personnel. Trauma meetings are organized monthly and they are intended for all personnel that have treated the patient in different time of the patient care in hospital. In these multi-ward, multi-professional meetings a patient case is given retrospective analysis and different key-decisions are discussed in aim to learn.

### **How is, or should, CPD be financed?**

*Niels Oerlemans (NVZ, The Netherlands)*

The Dutch hospitals branch is to invest an extra half a billion euros in the quality of its staff over the next four years. Furthermore, they plan to this this in a particularly creative fashion, with a measure that limited certain working conditions being turned partially into a subsidy for strategic staff training. Strategic training is currently on every hospital agenda. 'In that respect, the Netherlands is completely unique in Europe. I've noticed this trend, for example, in the contacts I have as Secretary General of HOSPEEM, and during the European meeting of healthcare employers and employees', says Tjitte Alkema, Labour & Training Manager at the Dutch Hospitals Association (NVZ).



### *Future-proof health care*

'Since the KIPZ (Dutch Hospital Staff Quality Boost) subsidy scheme was introduced over a year ago, we have seen hospitals put their strategic training policies into practice and invest in the qualifications of their hospital staff. The aim, both now and in the future, is also to continue providing health care that is safe, reliable and high quality.' Earlier this year, health care in the Netherlands was again rated highest in Europe, and we want to continue providing that level of care. The Netherlands sets an example for other European countries with the way it stimulates strategic staff training. We have noticed that a great deal of attention is being given everywhere to the hospital care that will be needed in 2020. The way we are dealing with this issue and further developing it is attracting international attention', Alkema explained.

### *More complex health care demands more of hospital staff*

The NVZ manager added that health care is going to change both drastically and rapidly over the next few years. 'People are living longer and have increasingly serious and often multiple disorders. These are disorders that until recently were often fatal, but can now be treated and thus become chronic. Medical technological possibilities are also increasing, while at the same time policy dictates that patients stay at home for as long as possible, as is often the patient's wish too. This means that as time goes on, hospitals will accommodate primarily those who require intensive and complex care. All these developments will make new and greater demands on health care and hospital staff.' The challenge for hospitals is to incorporate these developments into the care that will need to be provided in 2020, care in which the patient will be the main focus. Hospitals are therefore once again placing their processes, and the care they offer, under close scrutiny, asking themselves the following: Are we focusing on the right patient groups? Are we offering them the services they need? Are we working efficiently? Is extensive cooperation needed within the health care chain in order to remain successful? These questions in turn lead to talent management questions: What kind of staff will we need in the future, what should they be able to do and how can we keep them employable? Furthermore: who do we have at present and what should we be offering them?

We have also noticed that 'staff expertise' is an important core concept in the visions, missions and strategies set out by hospitals. The KIPZ has helped to ensure that the course of direction hospitals plan to take now also considers current and target situations with respect to strategic staff training policies.'

### *Strategic training plan*

In order to be eligible for the subsidy, hospitals had to draw up a strategic training plan in 2014. These focused on question such as: What qualifications must staff have? What level of training is required of them? They were also asked to provide an annual report on the activities carried out as part of the plan and in order to achieve the set goals. Alkema regards KIPZ thus as a relatively unregulated subsidy; it does not impose further high administration costs on hospitals.

The NVZ supports hospitals with the KIPZ subsidy and with the realisation of their strategic training plans. Alkema: 'We have set up a separate project organisation and, as a trade association, we offer our members tailor-made activities. These are widely appreciated, particularly as it appears to be difficult for many hospitals to incorporate this subject into their organisational objectives as strategic plans. This is partly due to the fact that staff systems often lack the essential information needed to analyse current staff situations. Moreover, many hospitals find it extremely difficult to plan further ahead than a year due to the many changes in health care. They have indeed been operating in a highly dynamic and unstable environment over the past few years.'

#### *Training interventions for staff*

'For many hospitals, the quality and safety of health care, leadership and client friendliness are important starting points with respect to training interventions for staff. Many hospitals regard nurses as a crucial group of staff when it comes to the quality and safety of health care. Studies including the European RN4Cast1 study show that strategic choices regarding the utilisation and qualifications of nursing staff can determine patients' health outcomes. Hospitals therefore analyse the optimum way to utilise nursing staff with a particular level of qualification. This is carried out using applied research on pilot wards, for example. Furthermore, several members of the NVZ, in collaboration with RAET and affiliated parties, have made it their business to ensure that hospitals are able to analyse their nursing staff data. Once hospitals know what kind of talent they currently have at their disposal, they can also steer the future towards the desired direction.

#### *Leadership*

Leadership is also an important theme in many of the plans, according to Alkema. 'The KIPZ ensures that hospitals develop a vision on the leadership style needed in their organisation. This can be interpreted as: What do we need from our managers and what do they need in order to fulfil their task so that organisational objectives are realised? This means more than knowledge and expertise alone. It is also about the desired organisational culture and the educational climate.'

'In 2014, hospitals made a great start with talent management by drawing up a strategic training plan. The next step is to evaluate all of that talent in the organisation. It is, of course, then important to work towards optimum utilisation of all that talent. This has dual benefits. The institution will be able to meet health care demands in 2020, and staff will be able to make the best possible use of their talents!'

### **Competentia – Roles and activities of a paritarian organisation to promote and support CPD for care workers**

*François Xavier Lefebvre (Competentia, Belgium)*

My presentation will show how a transversal perspective of skills, developed through social and care sectors can have a positive impact on LLL.

Competentia is a project aiming at setting up ready-made tools for skills 'management. The project is sustained by Funds but also Regional authorities.

**Crew Resource Management: a Dutch example of building health care teams focusing on effective communication and leadership.**

*Erica Overeem (Gelre Hospital, The Netherlands)*

There are many ways of learning: in the classroom, digital, in groups, at the work floor, etc. To work safely in a hospital it is important to pay attention at the functioning and learning of teams of doctors and nurses. This is called: Crew Resource Management. CRM is developed in the aviation. The disaster with a plane in Tenerife made clear that communication, situational awareness and specially the openness to ask every question or share every doubt one can have around decisions that are made, is fundamental to work safely. The parallel to health care is obvious. Gelre hospitals have developed a program of training teams in these non-technical skills. Learning from scenarios in a team with video feedback and debriefing have turned out to be very strong and effective. Nurses and doctors feel more equipped and secure about how to behave and work together in acute and stressful situations.

**Good practice: Short video instructions at the moment of need**

*Jaco van der Worp (Groene Hart Hospital, Gouda, The Netherlands)*

Landsteiner Institute needed a way to provide its hospital staff timely and practical training as they perform their daily tasks. We work several years with formal training, but we missed performance support for workplace learning to use additional to the formal training.

We now provide short on-demand video instructions at the moment of need, we call it EPSS: embedded performance support system. For the nurses we use the name 'asQme'. The library of instructional videos is easy to access. In this presentation we will share how we use video to support just-in-time learning.

We will present a few best practice examples from the Green Heart Hospital how we support nurses when they work with medical devices they don't use every day. Subject matter experts make their own user generated video's, nurses can open these video's with their mobile phone or on a desktop computer. With Performance Support we also support our cardiac care nurses who can be called to action in the weekend. With the short instruction video's they are able to learn at the moment of need.

In this co-creation project with the publisher Noordhoff, we developed a performance support system and a Dutch healthcare video catalog. Noordhoff has the tools, the Green Heart Hospital does the testing and implementation at the workplace. By doing this, we hope to save time and money and improve learning outcomes and quality of care.

### **Good practice Spaarne Hospital (NL): Escape room seduces to learn about safety**

*Cuun de Jong and Priscilla Verwoert (Spaarne gasthuis, The Netherlands)*

In the Netherlands, the national patient safety week is organized once a year. Looking for an innovative way to create more awareness on the patient safety theme in the Dutch Spaarne Gasthuis, a large teaching hospital, we developed The (learning through) escape room.

An escape room is a game where you get locked up together with colleagues. The group has to escape from this room within 30 minutes. For this, they have to solve puzzles, riddles and mysteries. If the group succeeds, they will find a code to regain freedom.

The escape room is a real team effort. The team has to think critically, creative and logical and also needs to collaborate, communicate and show leadership under serious time pressure. To increase the learning efficiency the escape room experience is followed by a 30-minute debriefing. The debriefing is led by an observer who asks reflective questions. If desired the participants received individual recommendations for further learning concerning safety issues.

The escape room was available during the whole patient safety week for all Spaarne Gasthuis employees. Due to its success it's still in business.

In this breakout session we will take you along in the development of the escape room, the experiences and the lessons learned.

### **The Roadmap: A Dutch example of organizing support for Continuous Professional Development that fits within the ambitions of the organization and its employees**

*Harm Landman and Hannah Wahab (Noordwest Ziekenhuisgroep/North West Hospital Group, Alkmaar, The Netherlands)*

In 2015, the HR department of the Noordwest Hospital Group (Noordwest) identified three policy areas which it wanted to improve on: the strategic workforce planning, annual appraisals and mobility & employability. These goals were set out in its 2015 policy plan, aimed at substantive improvements and greater internal cohesion in order to contribute to:

- The Noordwest strategic vision, mission and core values, by securing and continuously improving professionalism and professional conduct, now as well as in the future.
- Better organizational results by having the right amount of employees with a right male/female ratio, in the right place at the right time.

- The alignment of the ambitions of the organization with that of its employee's, by facilitating and stimulating internal mobility of employees in alignment with organizational developments.
- Sustainable employability (vitality) of employees.
- The involvement of all employees.

In Progressional People we found a good partner to address these policy ambitions throughout the organisation. Their approach was to expand the organisational vision on these subjects and set-up an application to facilitate the policy ambitions and provide coherence. The following steps were taken:

1. A digitized job classification system with which functions can be created, adapted and developed. In addition, employees can investigate their own career opportunities by comparing their current job with a job they aspire to; displaying the differences in activities, knowledge and skills. The digital job description also serves to evaluate work performance.
2. By mapping both national and regional job demands together with demographic and organizational data, the strategic workforce planning was given an impulse. It made clear which target groups (functions) the organisation had to focus on in the coming years and what skills employees needed to develop. Important target groups for Noordwest include post-initial education programs for nurses, Hbo<sup>3</sup>-qualified nurses and employees whose job will change due to further digitization.
3. A new approach to the annual appraisals was developed, whereby the employee's role is considerably larger. Individual competences are added and the personal ambitions of the employees are discussed explicitly in relation to the developments of the organisation. Thereby encouraging the mobility and employability of employees.
4. The implementation of an employee portal was the fourth step. Employees can use this portal to envision their career opportunities and ambitions. Based on a personal profile, the application displays possible career opportunities for the employees. Also the available professions / vacancies in the region and befitting education and training are displayed.

The development, preparation and implementation of this project at Noordwest was taken up by managers and employees alike, in workgroups as well as in advisory groups. The training of managers and employees is now part of the implementation of the new annual appraisals. During the project feedback is collected (often positive and also critical) contributing to the continuous improvement of the project.

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<sup>3</sup> Higher vocational education

## Appendix 4: Message wall posts

During the conference, delegates were encouraged to write messages on post-it's and stick them on a dedicated wall in the conference room. A total number of 52 messages were placed on this wall. They were written in English, French, German and Dutch and are reproduced below in English only.



*'Given the increase of the retirement age and the ageing of caregivers, training and professional roles allowing workers to be redeployed in the health sector must be developed.'*

*'CPD and LLL lead to a more effective and improved recruitment and retention of health care.'*

*'Investments in formal and informal learning are important. Now and in the future.'*

*'CPD is very important, it is necessary to find sources for staff to take part in it.'*

*'CPD & LLL FOR ALL WORKERS.'*

*'Investing in CPP/ LLL should be done independently of the economic climate.'*

*'Training is an asset, not a cost.'*

*'CPD should be part of strategic personnel planning. Invest in the future. Use knowledge available within generations.'*

*'Turbulent working life needs a more work-based learning culture. Organisations are also learning environments.'*

*'CPD for nurses is needed as they have more and more obligations. CPD can be helpful to raise their satisfaction at work, to raise their salaries and to prevent being overloaded'.*

*'Communication between health professionals is very important as a lot of errors in patient management are related to incomplete information.'*



*'We must work together, we must train together, we must share knowledge'.*

*'Inter-professional cooperation and skills development are essential in care for vulnerable elderly people. Important to show leadership (management support).'*

*'CPD and LLL will be rewarded. Investing in workers => investing in better care => less problems. '*

*'There is no rationale for accreditation.'*

*'CPD = investigation = NOT ONLY COLLECTION CREDITS'*

*'Not only the outcome but also the learning process (plan and reflection) should be recognised as credits.'*

*'Learning is a process, not an event.'*

Learning is a  
**PROCESS**  
NOT AN EVENT

*'Learning is a process, not an event! Not only collection of credits. CPD should be relevant.'*

*'Using credits that recognise the process of learning rather than isolated events.'*

*'Learning is a continuing process'.*

*'The human being since its birth is formed by learning in an empirical way. It is formed by its parents then by the national education and subsequently by the school of life. Lifelong learning must be a continuum.'*

*'Training is not the only solution to increase the knowledge.'*

*'CPD should not lead to an additional burden for health professionals.'*

*'Make better use of resources! Make use of all knowledge, skills and competencies existing.'*

*'Emphasize interprofessional teamwork roles to improve CPD. No single professional sector in health care can work alone.'*



*'Do not only invest in vertical careers. In healthcare there are great opportunities for horizontal careers. For example as wound care expert or ErgoCoach.'*

*'Successful models of CPD are done in a participative manner building on the expertise of councils and committees, but also involving patients.'*

*'For education, you need to find the balance between individual & organizational needs & motivation.'*

*'Value the professional training, but also the informal learning. Allow workers to put what they have learned into practice and to share what they have learnt.'*

*'Need to have an open mind for creative ways of CPD. Dare to test new things.'*

*'Training should be relevant and fun'.*

*'It is essential to link training also to the individual needs of workers. CPD courses/ formats need to evolve in the light of the changing world of work (modern technology, digitalisation...)'*

*'It is important to promote and give added value to training, including informal training. Workers must be given the opportunity to put in practice and share what they have learnt. Open-mindedness is needed (creativity, try new things).'*

*'Everybody is different. For the best result learning has to be custom made'*

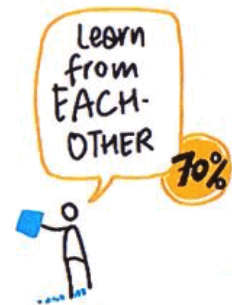
*'It is evident/ logic that CPD needs to be individualised/ adapted to the individual worker's needs. We need to start a virtuous circle and dare to change the perspective we have on the CPD and LLL. Possible starting points:*

- Hospital/ enterprise
- Sectoral level
- National level.'

*'The most you learn from your colleagues (70/20/10).'*

*'New ways of learning, gamification. Learning can be fun. The escape room is an example of this.'*

*'CPD oriented to personalized medicine approach - to be developed!'*



*'Interprofessional cooperation & skill development'.*

*'It is crucial to involve the leadership from beginning to make a project succeed.'*

*'E-learning and other CPD should be also provided in time. Due to shortages of employees, there is no time during working hours. So these nurses who are already exhausted from their work should train themselves in their own time. This should be implemented in their working scheme.'*

*'The good nurses in the hospitals are not the Master's or PhD's. Good nurses can rely on both knowledge and practical skills.'*

*'Health for people or health with people! How can workers use what patients tell them?'*

*'CPD is one thing but we did hardly talk about LLL. Due to work longer before going to be pensioned. So many nurses will not be able to continue this hard work. LLL should help them to find another job.'*

*'HOSPEEM forever because we want to share for better care'*

*'Can health workers be obligated to follow CPD courses? Why not? To the essence that CPD is presented/ offered in a positive/ supportive manner that is/ would be OK, as long as it is done with a logic of giving incentives. We need to also bring CPD formats/ programmes into the works councils and to have participative employers.'*



*'Beware, technical developments and digitalisation do not happen in a fortnight. Anticipate on the future, offer adequate and up to date training'*

*'Training must be financed exclusively by the employer. The employer must be attentive to the workers and listen to them in order to adapt their needs to continuing professional development. Training must be useful on the ground to give workers some form of recognition.'*

*'Need for coordination and cooperation with public institutions/ government to have sustainable funding of CPD. Good models are ear-marked funding, anti-cyclical funding & based on safe budgets for CPD strategic planning/ plans for CPD (formats, groups, design).'*

*'Big hearts are needed in big changes.'*

*'Involving patients is our challenge in educating professionals. Inspiring is the best practice.'*

*'After these two days, what do we do concretely? What concrete actions can we take? European social dialogue only makes sense if there is social dialogue at national level. The role of social partners should be to encourage and guide this local social dialogue while having requirements that give everyone a boost (and not the lowest common denominator). Dare to have ambitious requirements that meet clearly defined goals (quantitative and qualitative). Budget restraints are often the perfect excuse to forget training. CPD and LLL are essential but nursing skills are important'.*