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Extending the Strategic Reach and Impact of Healthcare Professional CPD

Constructively Aligned and Theoretically Underpinned

INTRODUCTION

"Education is what remains after one has forgotten what one has learned in school."
(Albert Einstein, 1879-1955)

The 21st century has seen the emergent need for continuing professional development (CPD) within the health and medical professions to address not only the individual needs of clinicians to ensure their knowledge is current but that it serves a greater collective purpose in relation to the healthcare workforce (Lewis, 2023). From a theoretical perspective, seminal epistemological theories of learning remain unchanged but the challenge of how best to facilitate disciplinary experts in remaining motivated and passionate about learning opportunities amidst the pressures of their daily workloads remains an issue for address. Time and fiscal resources are the two attributable factors to engagement in practice, but this does not detract from the passion that most healthcare practitioners demonstrate in the context of patient centred care, where applied knowledge is fundamental to optimal healthcare outcomes.

The foundation of Social Learning Theory rests on the theoretical basis of experiential learning and where the work of constructivist theorists such as Vygotsky still has resonance today (Rapanta, 2023). Whilst individuals may have preferred learning styles, curriculum justification, design and development remain

towards the domain specificities of the psychomotor, cognitive, and affective, with acknowledgement that it is experience which forms the basis of the tacit knowledge that becomes second nature to experienced clinicians and healthcare professionals in practice (Johannessen, 2022). Constructivism therefore lends itself to the differentiation of a job versus a vocation, where tacit, experiential knowledge becomes an embedded part of the clinician on a personal as well as a professional level.

Structured frameworks for curriculum development ought therefore to recognise the significance of the need for evidence-based approaches to teaching knowledge, skills and facilitating the consideration of the critical reflexivity that underpins attitudes and expressed behaviours at the front line of patient care (Ng et al, 2022). This also enables criteria for the assessment of quality to become an integral part of curriculum development against which the gauging of optimal practice can be made.

The foundational basis of extant knowledge is what Vygotsky used to frame constructivist approaches to learning, where the interdependency of experience and current learning are clear.

CRITICAL REFLECTION, REFLEXIVITY AND TRAJECTORY PLANNING

Critical reflexivity in practice is now an integral part of all healthcare work. There are few models of reflection that fit all healthcare practitioners but the notion of reflexivity (defined for the purposes of this article as the ability to react to a similar incident in the future with informed discernment and reflection on previous incidents) is common to the majority (Cribb, Entwistle & Mitchell, 2023). Reflection necessitates the consideration of the multi-faceted nature of knowledge construction in a real world that is littered with nuance and complexity that must be negotiated and articulated carefully (Schaepkens, Veen, & de la Croix, 2022). This is what becomes of all healthcare provision – it is rooted in the unanswerable question and most celebrated of all human attributes i.e.) what it is to 'be'. How we understand and apply meaning to how we interact with others in the context of healthcare provision for individual people, regardless of their physical or mental capacity in being part of the world, defines and frames our societies and our contributions to them.

STRATEGIC CONTINUING PROFESSIONAL DEVELOPMENT

CPD remains a main tool in the armoury of healthcare organisations whose strategic priorities are directed towards addressing both innovation in practice and quality improvement in care. Typically achieved via the integration of competency based CPD, geared towards contemporary practice, rather than a more straightforward refresher of knowledge and certified qualifications already gained by staff, this has ensured that CPD is now a dynamic and progressive process which actively frames what lifelong learning now is (Sockalingam et al, 2022). Most designated role profiles within healthcare professional roles incorporate compulsory CPD, alongside this being a formal requirement for the maintenance of registration with Professional Regulatory Statutory Bodies. How postgraduate curricula are developed, designed, and implemented in practice are therefore fundamental to how qualified healthcare professionals build and extend their competence, knowledge, and affective skills to ensure an optimal 21st Century workforce. Evidence to date suggests, however, that the way most are offered, do exactly the opposite, where staff fail to see the relevance of CPD to applied practice in health and there is minimal evidence of the constructive alignment of assessment mechanisms and outcomes with teaching and learning opportunities. Being able to engage personnel in CPD opportunities that are meaningful, relevant, timely and achievable within the context of an everyday workload are therefore pivotal to supporting and facilitating them in sustaining the degree of self-efficacy required to maintain professional standards.

ESTABLISHING COMMUNITIES OF PRACTICE

Qualifying as a medical or healthcare professional provides an insight into the capacity and capability of new members of often longstanding workforces (Van Duin et al, 2022). Becoming an integrated part of the professional community necessitates a temporal shift into collective and established professional identity over a period of experiential learning and adaptation to a new workplace habitus. An initial part of adapting to a new workplace in health and social care is about establishing what self-actualisation may look like in terms of short and long term career trajectory planning and the identification of how the profession to which a medical or allied healthcare professional belongs may be able to facilitate this, in terms of developing specialist, interprofessional or transdisciplinary praxis, all of which can be designated Communities of Practice in their own right (O'Brien & English, 2022). What characterises experiential learning is its capacity to provide contexts of learning within the workplace where CPD provision can be created to facilitate learning 'in situ'. It is of particular use within the context of the healthcare workforce since it focuses specifically on the progressive development and sustenance of competency and optimal work-based praxis. The outcome of optimal processes of critical reflexive practices are usually dependent upon building of experience from practice and the ability to be able to engage in formal reflection and how experience from clinical or professional practice can subsequently be used as an iterative means of dynamic and ongoing improvement. Transformative Learning Theory, as posited by Mezirow is a pivotal means of encouraging staff to deconstruct their long-held presuppositions and assumptions and to make purposeful meaning from practice-based experience (Mezirow 1978, 1990, 1997). His advocacy for introducing the concept of a disruptive dilemma, in the form of deliberately designed complex ambiguity, can be used to activate critical thinking and critical reflexivity. In turn this enables the changing of mindsets and mechanisms of dealing reflexively with anticipated future events.

In tandem with the notion of communities of practice is Social Learning Theory, which are also largely dependent on the social context of learning and the collective learning communities within which this happens, which are of direct relevance to CPD provision (Lave and Wenger, 1991, Wenger 1999). These theories are heavily reliant on the acknowledgement that education is a social activity, of which critical thinking, proactive discourse, and a capacity to listen are essential components. Education is situationally specific and *what* is being taught is inevitably influenced by *where* it is taught and its relevance to where the application of newly gained knowledge will be applied in medical and healthcare practice.

CULTURE, CONTEXT AND BENCHMARKING KNOWLEDGE AND SKILLS ACQUISITION

Organisational culture has a tangible impact on the motivation, satisfaction, and wellbeing of the healthcare workforce. Self-determination theory acknowledges the need for both motivation and a capacity for critical reflexivity as fundamental mechanisms of driving adult learning. Central to this is a sense of belonging to a greater whole and a sense of being valued and acknowledged for the individual contribution that each member makes (Kusurkar and ten Cate, 2013). By observing iterative student cohorts, Perry (1999) reported that students exhibit an adaptive approach to learning as they progressed through their studies. In terms of class, these students were relatively privileged in terms of their fiscal means, academically very capable and not afraid of open questioning where they necessitated clarity on any given aspect of their academic studies. Belenky and colleagues shifted the framework from transactional approaches to pedagogical practice so that the co-construction of knowledge can become an integral part of knowledge extension and

capacity building (Belenky et al. 1997). This was something which certain facets of society did not realise they had a right to do since the power relationship between those who imparted knowledge and those who absorbed it was too great for a dialogical relationship of equality. Being able to benchmark intellectual development is central to being able to see the tangible progress that each member of an individual member of staff is making, a key indicator of progression was a shift from binary thinking capacity into the ability to be able to work and adapt to complex ambiguity in the workplace, where the contextual significance of the workplace is everything in terms of decision-making capacity (Perry, 1999).

KNOWLEDGE CO-CREATION IN POSTGRADUATE CPD CURRICULUM DESIGN

Integrating students as partners alongside other key stakeholders in the co-creation of academic curricula has become an expected norm in the context of CPD development in healthcare professional education. The central aim of CPD is to ensure the holistic impact of the workforce can be evidenced in terms of problem-solving ability, sustainable employability, and wider social impact within organisational culture. The mechanisms via which this aim is achieved are subsequently aligned with the need to consider pedagogic practice, which is meaningful, pragmatic, efficient and purposeful in terms of addressing the generic transferrable skills needed in the context of applied clinical and professional practice. Contextually this happens amidst an uncertain contextual backdrop of politics, change and institutional culture, which was especially apparent during the global COVID-19 pandemic (Manley, et al, 2018).

Enhancing the concept of learner agency ensures the notion that authentic learning can be embedded across CPD curricula. In terms of 'graduateness' this can be characterised by the transition from superficial to deep learning processes, ensuring that learning can, as far as possible, provide a transferable skill base relevant to the needs of patients at the front line of care. It also facilitates the notion that progression to further learning can be advocated throughout CPD, so learners are afforded the opportunity to embrace the notion of lifelong learning within their individual employment niche (Drude, Maheu & Hilty, 2019). The term 'CPD curriculum' can be defined as the overall holistic structure and individual content of a CPD course but which extends beyond the academic to the social, in terms of strategic impact. It is possible to contend it is indeed a lens through which healthcare professionals' active participation and co-creation can be illuminated and extended (Bovill, 2014).

When contextualised within individual Higher Education Providers, of which healthcare CPD is an integral part, all co-creation of curricula can be regarded as a fundamentally unique case study that is contextually bound and usually framed within a specific signature pedagogy or academic discipline. These specific case study illustrations are used to further inform evidence based and informed decision-making processes involved in curriculum justification, development, and subsequent implementation. This insight essentially provides a means of addressing the inclusivity gap in CPD but also provides a creative tension in defining the culture and commitment of healthcare organisations to democratic and fair processes of social development and robustly executed progressive development. The nature of all health and medical CPD curricula are shaped by both formality and informality – what is bracketed under each can be startlingly different and can subsequently be engaged with by students as part of any learning that ultimately contributes to a holistic education system designed to ensure the optimal care of patients and their families and carers.

CONSTRUCTIVIST PERSPECTIVES AND SOCIAL LEARNING THEORY

Allegiant to the theoretical basis of Social Constructivism, Vygotsky & Cole (1978) remains the greatest of significance in relation to work and practice-based learning. In terms of functional pedagogy, the Zone of Proximal Development is the iterative supportive framework that is used as a means of moving learners from dependency on their teachers, to complete professional and clinical autonomy. All iterative learning within this theoretical perspective, is dependent on the nature and meaning of pre-existing knowledge that the learner has. Within the context of a community of practice, shared collective knowledge can be pooled together and used to construct individual contributions to knowledge into a far greater whole. The whole process of proactive comparative knowledge is central to the learners' discernment of the validity and reliability of newly formed knowledge (Rittle-Johnson, Star & Durkin (2009). Whilst not all models of constructivism are purist in nature, there is a clear distinction between what can be provided between the pre-existing knowledge that learners have and the juncture between this knowledge and that which is added to it. It is here that active comparison is used by learners to validate and authenticate what is being presented to them as new knowledge and to weed out complex ambiguity in practice. It is this capacity for critical reflexivity and discernment which constitutes the higher order thinking of healthcare and medical professionals, who deal with the complex ambiguity that health and medicine present daily.

MEANING MAKING, TRANSFORMATIVE LEARNING AND EPISTEMIC COGNITION

'Meaning making' can be defined as the interpretation of phenomena or events which can be deconstructed, interpreted, and reconstructed as the healthcare workforce make sense of the information, experience, and values they are facilitated in sustaining and developing. The opportunity this affords learners though, is one which can potentially embed an ethos of informed creativity in the development of co-created curricula. Historically, this has been one of the critical yet tokenistic elements of integrating and extending democratic values into CPD provision. In terms of the positional power of learners relative to their place in the organisational hierarchy and stakeholders this has gone some way to redressing imbalance in the inclusion rather than the representation of active learners in curriculum development.

Transformative learning becomes an embedded part of the knower; it is what provides the 21st century workforce with transferrable knowledge and which ought to equip them for lifelong societal contribution not just the concept of employability within health and medicine. Interpretation is as much embedded in epistemic cognition as relaying a story or meaning, one which can be defined in planning as procedurally combinational (Kelly, 2016). The term combinational refers to information processing and the subjective recall of information that means specific information can be retrieved from memory and articulated. It can clearly be argued from a social constructivist perspective that memory is dependent on transformative learning which becomes an embedded part of the knower and subsequently the focus of any conscientious curriculum development process.

FUNDAMENTAL APPROACHES TO THE CO-CREATION OF CURRICULA

McInnis, Ramsden and Maconachie (2012) described the collaboration of students in the co-creation of curricula as change agents in terms of how they could effectively shape learning experience for their counterparts in learning. The concept of authentic learning across pre-registration health and medical undergraduate degree programmes has become apparent through the multifaceted approaches to placement integration and work-based learning. Consequently, ongoing CPD is reflective of this. Billet (2014) has advocated strongly, the difficulties in developing curricula that focus on applied clinical and professional practice and the capacity of these curricula to potentially harness CPD student agency. Integration of modularity (individual units of study which collectively form a wider programme) is pivotal to the success

of ‘programmeness’ (the holistic integration of curriculum content that can be constructed from social opportunity as well as academic learning). Being a proactive member of the curriculum development team in a participatory context enhances learner capacity for deep learning, yet often Higher Educational Institutions with strategic responsibility for the development of CPD modules and programmes adopt a tokenistic approach to their inclusion and the value of the active contributions of the workforce (Bovill, Cook-Sather & Felten, 2011).

Tinto and Pusser’s (2006) now seminal acknowledgement of the discourse and narratives surrounding learner engagement have facilitated a move in pedagogic research and practice to realign and refocus CPD content to that of experiential learning processes in applied clinical and professional practice. This, in tandem with Bovill’s (2014) contention that facilitating the process stems from an organisational capacity to advocate cohesion and autonomous self-direction in the development of professional practice, has changed the face of CPD co-creation and added immeasurably to the opportunities the healthcare workforce are now afforded in contributing to the design of tailored lifelong learning opportunities. The workforce also ought to have a systematic mechanism of being responsive in the proactive engagement of healthcare and medical staff as co-creators, who individually experience processes of learning and tangibly feel inclusion at the forefront of CPD learning pathways in the context of both their personal and professional development.

ETHICAL DIMENSIONS OF CPD CO-CREATION

The co-creation of CPD curricula is about more than amplifying the ‘learner voice’ or developing the visibility of democratic decision making in the politically fraught context of CPD for medical and allied healthcare professionals. It ought to be about integrating them in a process of participatory action research, which as a by-product equips them with several defining characteristics (Peel, 2005). Learners should be facilitated in becoming postgraduates who have been enabled, prepared, and elevated in self-belief and confidence by the process of working collaboratively for the benefit of their subsequent CPD cohorts.

Amidst the potential for these attributes to be developed, there ought also to be a clear ethical consideration of the impact of engagement in the co-creation of CPD curricula. The complexity of the ‘real world’ is an addition to the time constraints staff have in working towards their CPD studies, their assessment processes and significantly, their opportunity for adjunct social integration and relaxation opportunities. Since it is often the latter two, which are is sacrificed by staff to engage with CPD, healthcare organisations must remain cognisant not to overburden students or place unrealistic expectations on them as they become key change agents in the strategic development of meaningful CPD. This engagement on a positive note, can be regarded as an activity that will enhance students’ abilities as problem solvers and decision makers to engage professionally and to demonstrate a capacity for self-regulation and deep learning (Litchfield, Frawley & Nettleton, 2010; Hearle & Cogger 2011; Cook-Sather et al., 2015)

GUIDING PRINCIPLES FOR CPD CO-CREATION

The provision of a theoretical framework for implementation of CPD curriculum development that can be metrically evaluated and justified in terms of impact beyond anecdotal evaluation is essential (Patja et al, 2022). The impact of workforce engagement in the process, also needs evaluation and monitoring in terms of the ethical basis of healthcare personnel inclusion in curriculum development and indeed how far the commitment of the workforce to this endeavour should stretch in relation to their other clinical and professional commitments as lifelong learners (Jackson & Manley, 2022). The table overleaf illustrates this:

STAGE 1: INITIATION	ACTIVE PROCESSES	RATIONALE FOR IMPLEMENTATION IN CPD
	Clear framing and operational definition of proposed CPD curriculum development in relation to signature pedagogies and disciplines and the interdisciplinary or multi-disciplinary nature of the CPD required.	✓ *Reduces ambiguity and provides methodological focus.* ✓ *Outlines procedural regulation and quality assurance processes.* ✓ *Ensures meaningful content is addressed from the initial stages of design.*
	Acknowledgement and critical evaluation of the extant published literature and evaluative documentation and feedback on current processes of CPD.	✓ *Enables theoretical constructs of curriculum design, justification and development to be grounded in the published or acknowledged extant evidence base.*
	Identification of issues of inclusivity throughout the CPD curriculum.	✓ *Maintains and develops theoretical flexibility in the curriculum development process.* ✓ *Ensures issues of equality and diversity are integrated and embedded into the programme.*
	Consideration of how an existing theory or hypotheses could impact on the focus of inquiry within CPD opportunities.	✓ *Potential for the integration of best practice into CPD curriculum design, development, and implementation.*

STAGE 2: EVALUATIVE CASE SELECTION AND SAMPLING TECHNIQUE	ACTIVE PROCESSES	RATIONALE FOR IMPLEMENTATION IN CPD
	Define a specific research evaluation population from the context of CPD curricula provision.	✓ *Enhances the external validity of the findings to be integrated back into inclusive academic curricula.* ✓ *Aids in establishing the power balance between academics, stakeholders, and students in the development process.* ✓ *Ensures robust yet collaborative processes of curriculum development and justification in terms of what is quality assurance and quality enhancement.*
	Operationalise a theoretical sampling technique from extant academic curricula or if a new development, the approaches that have been implemented and adopted across other HEIs.	✓ *Provides a focused emphasis on those specific phenomena from extant curricula and evaluative commentaries that can prove, extend or develop further an existing evidence base.*
STAGE 3: DEVELOPING THE SPECIFICS OF CURRICULUM DESIGN AND METHODOLOGY	**ACTIVE PROCESSES**	**RATIONALE FOR IMPLEMENTATION IN CPD**

	Establishment and implementation of multiple metric and qualitative data collection methods /mixed methods approaches (focus groups / questionnaires).	✓ *Provides a mechanism of triangulating data so that theoretical emergence from the curriculum development process can be clearly grounded in theory. This enables an evidence-based approach to evaluation following enrolment of initial and subsequent cohorts.*
	The inclusion of multiple representative collaborators (academics, stakeholders and CPD students).	✓ *Strengthens grounding of theoretical basis of curriculum development by inclusive triangulation of the established evidence base.*
	The combined impact of metric and qualitative established in relation to the proposed CPD programme, institutional capacity to deliver and the recommendations of representative collaborators.	✓ *Combined and synergistic perspectives facilitated from the multiple contributors to the curriculum development process in relation to the collated evidence base.* ✓ *Facilitates the notion of divergent and inclusive perspectives and strengthens the methodological process of grounding.*
STAGE 4: ESTABLISHMENT OF AN INITIAL EVALUATIVE COMMENTARY	**ACTIVE PROCESSES**	**RATIONALE FOR IMPLEMENTATION IN CPD**
	Synergised data collection between collaborators in curriculum development.	✓ *Enables data enrichment from multiple sources (e.g., representative academics / students / stakeholders, ensuring quality assurance processes.*

	Implementation of potentially flexible and opportunistic data collection methods (e.g. extant Institutional Evaluative Reports, published pedagogical literature).	✓ *Enhances the analysis phase speed and provides purposeful and contextually relevant adjustments to the data collection process.* ✓ *Allows collaborators to exploit emergent themes and potentially fundamentally unique characteristics of a newly developed curriculum.*
STAGE 5: ANALYSIS PHASE	**ACTIVE PROCESSES**	**RATIONALE FOR IMPLEMENTATION IN CPD**
	Specific, focused CPD curriculum analysis of 'programmeness' and integration into 'modularity'.	✓ *Gain familiarity with evaluative data and preliminary generation of the academic justification for new or modified programmes.*
	Identification of emergent pedagogic theoretical perspectives for dissemination via conference / publication or best practice in CPD initiatives.	✓ *Collaborators can move beyond superficial thematic analysis to deep conceptual explanation of theoretical emergence in relation to inclusivity across the academic curriculum.*
STAGE 6: FRAMING AND ESTABLISHING A WORKABLE ACADEMIC CURRICULUM	**ACTIVE PROCESSES**	**RATIONALE FOR IMPLEMENTATION IN CPD**
	Focus on the implementation process of the new / adapted academic curriculum. The application of systematic logic across the operationalisation of the	✓ *Provides conclusive confirmation of pragmatic or operational issues that extend knowledge and*

	CPD curricula, identifying opportunities for piloting of new / specific components	*provide a strategic focus for pedagogic justification.*
	Examination of specific causation factors of the inclusivity gap in relationships and interactions – i.e.) the 'why' rather than the 'how' of where the CPD curricula are deemed non-inclusive.	✓ *Provides enhanced levels of internal validity to the newly proposed CPD curriculum that extends beyond a rhetoric of the 'ideal' closure of the inclusivity gap.*
STAGE 7: JUSTIFICATION OF THE CURRICULUM DEVELOPMENT PROCESS	**ACTIVE PROCESSES**	**RATIONALE FOR IMPLEMENTATION IN CPD**
	Iterative comparison with opposing and contested viewpoints from the extant literature / evaluative processes of CPD and affirmation of consistency with that which identifies issues of relevance to the progression of practice-based learners.	✓ *Enhances the degree of apparent internal validity that the CPD 'programmeness' can extend into its 'modularity'* ✓ *Highlights and extends the claim of external validity for the curriculum justification and development processes.*
STAGE 8: CURRICULUM DEVELOPMENT COMPLETION	**ACTIVE PROCESSES**	**RATIONALE FOR IMPLEMENTATION IN CPD**
	Statement of completion of the initial phase of CPD curriculum development and validation processes, which must be followed by iterative cycles of CPD evaluation and monitoring.	✓ *Provides a stage of completion for all collaborators, where new ones may be recruited for the next phases of development and progression*.

Table 1. Eight Stage Curriculum Development for CPD via Co-Construction with Learners – an adaptation of Eisenhardt's (1989) 'Process of Building Theory from Case Study Research'

THE PLACE OF TACIT KNOWLEDGE

At the heart of a values-based healthcare system lies the capacity to be responsive to different contexts of care, with the fundamental basis of care being dependent on the interrelationships that exist between one human and another (Liu, Bozic and Teisberg, 2017). Belying the capacity for complex decision making, the ability to discern the impact of their interventions, whether social or functional with people plays a fundamental role in their capacity to individualise and tailor care needs. Not only does this tailored care depend on a sound knowledge base, it also often needs to be clearly articulated to other working in healthcare provision so that concerns can be escalated, and additional support sought in the care and management of some of the most vulnerable members of our society. Tacit knowledge plays an integral part in the ability of any healthcare workforce to do this in the context of daily practice. Tacit knowledge is best defined as intuitive knowledge that is not easy to articulate through dialogue or rational justification (Thomas & Gupta, 2022). It depends on a level of sensory awareness or feeling that transcends the need for formalised knowledge in terms of its potential impact on practice. It is often associated with immediacy and thinking in the moment and is something that develops with experiential learning and that which makes the once unfamiliar, second nature in our everyday caring practice. With years of experience, it can be reasonably be assumed that some of the actions that healthcare professionals take are intuitive and 'second nature' rather than legalistic and dependent on specific frameworks (Corrao & Argano, 2022). From one human to another it could be stated that the intuitive responses are rooted in empathy and regard for the individual people who need care in practice. Since tacit knowledge is not a tangible resource and as such cannot be integrated into visible core competencies required of clinicians in practice, it is often little mentioned, yet is the knowledge that arguably characterises the very best of care in practice. Theoretically, the term was first posited by Polanyi (1958) who aptly stated, 'we know more than we can tell.' If we contextualise this in practice, and the CPD used to underpin it, it is the knowledge that tells us what an older person needs by their facial expression, their response, or their needs in emergency situations (Skoog, Hallström and Berggren, 2017). It is that which cannot be taught at training days and that which the care system depends upon most to provide a compassionate healthcare service that transcends class, status, age, or gender. It is a characteristic of personhood, often little acknowledged in our lives but that which is so important, we cannot afford to overlook as one of healthcare provision's most valued assets Undoubtedly influenced by both formal and informal learning, tacit knowledge is an innate and embedded part of who people are, not just what they can undertake as a performative exercise at the front line of patient care. What people need can never be fully articulated with discourse, but tacit knowledge based on being able to care for fellow man is where it stems from. Trainers and educators are also under pressure to 'measure' training and education – education packages are often treated like commodities or acquisitions that can make people care, whereas, in reality, care is something far beyond the reach of the functionalism offered by contemporary CPD. There is also a distinct difference between the concepts of intellectual capacity and knowledge, which is linked to how credible people are in practice as when knowledge becomes an integrated part of functional performance then applied practice is more highly valued (Sousa et al, 2017). Tacit skills harness the implicit knowledge that the healthcare workforce possess, regardless of their position within the organisational hierarchy, so that it can be effectively applied in practice. Central to this

is the capacity to effectively communicate and work as an integral part of a team. Table 2 (below is indicative of this:

CAPACITY AND CAPABILITY IN PRAXIS	FOCUS FOR CPD DEVELOPMENT
➢ Knowledge Based Skills ➢ Awareness of Context ➢ Ability to Make Decisions	✓ *The ability to use sense and intuition to understand and establish meaning and then predict the impact of this in the immediate future.* ✓ *The process of discernment that means a decision can be reached that will ultimately determine a course of action that fits the need of a given situation.*
➢ Social or Behavioural Skills ➢ Team Working Skills ➢ Communication Skills ➢ Leadership Skills ➢ Assertiveness Skills ➢ Personal Resource Skills	➢ *A collective and collaborative set of skills that facilitates approaches to multiple activity towards a shared goal / task.* ➢ *The capacity to actively exchange knowledge of information that includes concerns, intuitive response, suggestions and active ideas.* ➢ *The ownership of acting to maintain standards, plan, prioritise and make active decisions for the immediate and direct benefit of a person or process in the context of healthcare.* ➢ *The capacity to be confident in expressing an opinion, without the need for aggression.* ➢ *The capacity to demonstrate self-awareness and to demonstrate a personal capacity to demonstrate resilience under pressure.*

Table 2: Tacit Knowledge in Practice

Tacit knowledge has the capacity to drive informed decision making and decision making that has to be made immediately and that is not the preserve of the highly qualified. It is rooted in the base intuition of human engagement and pivotal to preserving the dignity and value of the patients for whom we care. It allows carers the opportunity to discern the very best application of explicit knowledge and to apply that at a tacit level for patients who are still regarded as individuals and whose care matters to those providing it (Davies, Powell and Nutley, 2016). The consideration has two main components; the initial one is of the situational and context specific nature of healthcare provision and why this is of relevance to the application of tacit knowledge in practice (Pawlowski and Bick, 2015). The other highlights the need for tacit

knowledge to be identified as an integral part of multi-professional healthcare CPD and how this can shape the confidence and motivation of the workforce to apply transferable knowledge in everyday practice (Ojha, and Yammiyavar, 2017).

CONCLUSION

This chapter has provided a theoretical insight into the complexities associated with the curriculum justification, design development and implementation of CPD curricula within the context of the healthcare workforce. Differentiating between individual and collective focus, whether via active Communities of Practice or individual ambition in terms of career trajectory planning within an organisational hierarchy have been examined in terms of the need for a structured and evidence-based approach to CPD in healthcare practice. Since upon initial qualification as a medical or healthcare practitioner still leaves extensive scope to become embedded within both individual professional identity and the collective identity of a specific signature pedagogy or discipline, then ensuring that Communities of Practice are accessible and equitable in terms of their operationalization is pivotal. The concept of critical reflection and reflexivity have also been revealed as key mechanisms of driving new knowledge construction and actively contributing to service improvement in the context of the healthcare workforce, with specific emphasis on person centred care provision. Constructivism remains central to being able to effectively build on pre-existing knowledge and ensure that this can be proactively validated and authenticated alongside new additions to it. In accordance with the need to make CPD meaningful, processes of transformative learning as an integral part of epistemic cognition have also been illustrated as a means by which learners can be afforded the opportunity to incorporate CPD into the wider scope of lifelong learning. The chapter has also highlighted the need to provide structured learning opportunities for staff, which incorporate ethical opportunities for the healthcare workforce to play an active role in the identification of CPD needs and the development of CPD opportunities which are meaningful, relevant, and timely, in terms of uptake by staff. Where guiding processes of CPD creation have been incorporated, it is possible to identify the specific challenges and potential for optimal outcomes that accompanies strategic planning and optimal processes of CPD programme evaluation. What remains of greatest significance though, is the impact at the front line of patient care that any CPD programme is ultimately geared towards. With health and medical staff working in some of the most challenging contexts and settings, it is pivotal that the quality of these programmes can be assured, alongside the authentic learning opportunities for staff to sustain their motivation and commitment across careers which may stretch over forty years.

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KEY TERMS AND DEFINITIONS

Communities of Practice: Within the context of the healthcare workforce, a community of practice (CoP) is a collective group of people with a shared common interest, set of issues or challenges and who join to ensure the fulfilment of specified individual or collective goal(s).

Critical Reflexivity: Critical reflexivity is defined as the capacity to reflect on self-perspective and long held presupposition and assumptions with the aim of understanding how these aspects of identity are socially constructed via critical reflection.

Experiential Learning: Experiential learning is process of educational engagement where students learn by immersive activity in the 'real world and then proactively reflecting on the experience to learn from what the experience has taught them and how they might refine their approach in the future as a means of iterative contemplation and improvement.

Lifelong Learning: Lifelong learning is the holistic nature of education, which focuses on personal as well as professional development in terms of career trajectory planning and work-life balance.

Professional Identity: Professional identity is defined as a healthcare professional's level of self-concept based on their individual attributes, beliefs, values, motives, and experiences. It can also be used to define what characterises individual professional groups or disciplines.

Signature Pedagogy: The term signature pedagogy refers to the specific mechanisms of teaching, learning and assessment, which are common to specific academic or clinical disciplines or professional groups. These specific mechanisms of learning often facilitate the building of professional identity and self-efficacy which enables learners to think and act in terms of higher order thinking, as experts within their disciplinary fields of practice.

Social Constructivism: Social constructivism places strategic emphasis on the collaborative nature of learning as a social experience. It is based on the premise that knowledge is a byproduct of the interaction of people within their different cultures and contexts and the societies to which they belong. Metaphorically knowledge building can be represented by bricks, where students learn from others and construct their own knowledge and reality.

Social Learning Theory: Seminally posited by Albert Bandura, Social Learning Theory emphasises the significance of observing, modeling, and imitating the attitudes, expressed behaviours and affective reactions of other people, whose individual professional identities can then be alluded to.

ADDITIONAL READING

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