

# Implementing the CPD programme

The Royal Pharmaceutical Society is shortly to begin implementing a generic system of continuing professional development for pharmacists. The system has been piloted among 500 volunteers and in the first week of October will be extended to cover 5,000 pharmacists, including all pre-registration tutors and tutor managers and a proportion of pharmacists in the north-west of England.

A progress report on the long-term CPD project and an outline of the communication strategy to be used in its roll-out were described to the Society's Council at its meeting on 6 August in a presentation by Dr Robert Dewdney, head of the Society's education division, and Dr Peter Wilson, consultant to the Society on communication and policy with respect to CPD.

## CPD IS MORE THAN CE

Dr DEWDNEY said that one message the education division had put across in recent years was that CPD was not the same as continuing education: although continuing education was a part of CPD, other forms of CPD, such as learning on the job, were also important. But a difficult new message also had to be got across. Discussions with pharmacists and others suggested that what people were really interested in was revalidation. In their minds revalidation equalled CPD — which it did not, although CPD was a part of revalidation. What the team was working on was a generic CPD system. A revalidation system required a lot of additional work.

The team was now about four years into the project to come up with a CPD framework. The initial aim had been to develop a voluntary system that they hoped to persuade all pharmacists to join. At the start there had been a pilot for about 18 months among 500 pharmacists, predominantly community and hospital pharmacists. The team had recruited more than 60 per cent of those they had invited to take part, which was a representative sample of the register. For some of them they had given one-to-one facilitation to see whether facilitation was a necessary component of the CPD framework. An important outcome was the need to find a way of objectively reviewing the CPD records submitted. The team had wanted to give feedback to pharmacists from the review process, and it had been able to do that.

This had been followed by a phase 2 pilot, which was just finishing. But the context had changed with the need to move to a mandatory CPD framework in the light of the Government's first White Paper on health and the Kennedy report. The team now had to go from testing to a development phase.

The next phase is really implementation phase 1. The team believed that CPD would eventually be computer-based, although a paper-based system would have to be retained for some years for a number of phar-

macists. They also knew that they had to bring in other stakeholders, employers and the national centres for pharmacy postgraduate education, because the Society simply could not afford the facilitation that had been available in the phase 1 pilot. The team would apply the type of system that it had worked on in pilot phase 2 to about 5,000 pharmacists, who would be this year's pre-registration tutors and tutor managers, the people in the original pilot areas and a proportion of pharmacists in the north-west of England. Identifying this last group was difficult because not only were the Society's regions not conterminous with those of the NHS, but things were also changing continuously with regard to workforce development confederations and strategic health authorities.

Participating pharmacists would receive a CPD pack which would be predominantly printed material. It would be brief, concise and attractive. It would be supplemented by web-based information that would also be accessible to other pharmacists. The Centres for Pharmacy Postgraduate Education was to put on a support programme for pharmacists in the north-west of England.

How would it all fit together? First, it was the intention eventually to have all pharmacists' CPD records on a computer server. A system was up and running. The system also dealt with pharmacists who wanted to use a computer but did not have access to the internet. In addition it would have to find ways of inputting information from paper.

At intervals the team would review people's CPD records, drawing from the server and not from paper. Feedback would go to the user. But eventually, at intervals, information would go to the Society, as regulator, as part of the revalidation aspect that had to be developed.

Importantly, other stakeholders would be able to access the record, but what they could access would be completely in the control of the user. That was already up and running. If a pharmacist wanted an employer to be able to look at some or all of the records, a password could be provided to allow the employer to do so.

The Society had talked to the major groups in pharmacy. One of them, Lloyds-pharmacy, was looking to import its own computer-held CPD records directly into the Society's system, so that pharmacists did not have to make double entries in the company's system and then into the Society's records.

## COMMUNICATIONS PLAN

Dr WILSON said that, because some pharmacists were apprehensive about what CPD meant for them, the communications accompanying the change needed to be directed at people's anxieties and tell them what CPD would involve for them over the next few years. The CPD advisory group had created a communications plan. It was a plan for a

range of people for whom CPD was going to be important.

First, it was important to communicate with some 40,000 pharmacists who, apart from the 500 in the pilot, did not altogether know what CPD meant for them. The other principal group with which communication was important was the employers. There was also the Department of Health, with which the Society would be working when it came to regulation. In addition, there was the public, in whose interests it was all being introduced, and the other health care professions.

The group had to explain what CPD was and what it was not. Essentially it would be saying that pharmacists learnt when they worked as pharmacists: their experience made them the sort of pharmacist they were. What they did not currently do, but needed to do, was to record what they learnt for others to see. That was the essence of what needed to be got across.

Pharmacists needed to record their continuing education. But CPD was more than continuing education. That was another important message to get across. People talked as if CPD and CE were the same, and that misconception had to be corrected.

The CPD framework would be extended to all pharmacists by 2004, when CPD was expected to become mandatory. The pharmacists who had worked in the pilot knew that it was practical and that they could do it. It was not a huge burden and could be carried out at the end of the working day, during the working day or at the end of the working week.

## GETTING THE MESSAGE ACROSS

How was the team planning to get the message across to pharmacists? First, the Society was working closely with the CPPE, which would provide a support programme for the pharmacists who adopted CPD in the first phase.

The Society would use various forms of printed materials. There had already been an article in *The Journal* (PJ, 25 May, p723) which contained the message about the roll-out beginning particularly in the north-west of England in the autumn and it was expected that there would be other articles and reports on CPD. The Society's CPD pack would go to all pharmacists involved in the first phase of the roll out.

The major means of communicating with the profession about CPD would be by the distribution of video programmes produced by the Society and CPPE: one programme would provide information and the other would provide practical support to help people adopt and practise CPD.

Why a video? It was an effective medium for getting a small number of messages across with high impact — more so than supplying information in print. It gave an opportunity to illustrate how CPD was practised, using testimony from pharmacists in the pilots who had found that CPD worked for them.

CPD would also be the focus of a range of meetings. Requests for speakers were coming in from Society branches, and it was intended to supply speakers who had briefing packs and materials to use to get a comprehensive and consistent message across to the membership. Priority would be given to the branches most affected — initially those in the north-west of England — but requests were coming in from other areas as well.

In addition to the membership as a whole, the communications plan would include the Society's special interest groups, other professionals and patient groups. Messages and articles about CPD would go on the Society's website. A lot of work still had to be done in the near future.

### COUNCIL PARTICIPATION

Dr Wilson concluded by asking at what point Council members would adopt CPD. He believed that when Council members spoke to the membership about CPD, it was better if they spoke from the basis of experience.

Mr DAJANI said that in answer to that question he would say "straight away". As leaders of the profession, Council members had to set the trend.

HEMANT PATEL asked whether the video would inform people about the need for CPD or contain material for learning.

Dr WILSON said that it would do both. It would start with a description of why CPD was being introduced in its broadest sense. It would then move into descriptions of CPD and stages of CPD as pharmacists had practised it, with examples of what they had done. People would be able to learn about the impact of CPD and how they could relate it to their own work as pharmacists.

Mr PATEL said that some 22,000 pharmacists worked in community pharmacy. They were busy people and many did not have time to read material. There was a need to look at using video and audio material presented in different ways, because people had different learning styles.

DAVID THOMSON (chairman of the Society's Scottish Executive) said that the dialogue used would have to be meaningful to the language used in the host country. That should be reflected in the training material used.

Dr WILSON said that the Scottish Centre for Post Qualification Pharmaceutical Education had been involved in generating the videos. Pharmacists in Scotland and in Wales would be on the Society's video. The materials generated would be available to the centres in Scotland and in Wales, and it would be possible to edit them to make them more appropriate for the audience in those countries.

ALISON EWING said that she was interested in the exchange of data with the Lloydspharmacy database and asked what the position was with regard to the NHSnet database hospitals.

Dr DEWDNEY said that fragmentation within the NHS was a big worry. The Society's main link with the managed service was through Claire Grout (head of pharmacy education and training, Greater Manchester

Workforce Development Confederation) in the north-west. The team saw a particular set of challenges with the managed service and that was one reason for choosing an area where there was an influential pharmacist at a high level and able to tell the Society of the realities that had to be dealt with.

Miss EWING said that the Society should not miss an opportunity to have a template that could be NHSnet-based. Every hospital and PCT could use that for pharmacist employees.

CLIVE JACKSON said that some pharmacists, such as those in the College of Pharmacy Practice, already recorded CPD. He used what he recorded for the college towards the Society's CPD database. Work was already under way to optimise the structure of CPD portfolios. Would there be compatibility?

Dr DEWDNEY said that discussions took place regularly with the CPP. It was intended to have a kitemark on other recording formats and to achieve a common data set with employers, the CPP and others which would allow electronic transmission and also allow the accommodation of other systems so far as possible. The Society did not want to ask people to do the same thing twice.

Mr JACKSON said he was pleased that the Society was promoting standardised approaches for record keeping. Could they be shared with other providers? It was important to minimise duplication of effort.

Dr DEWDNEY said that the criteria would actually be in the pack. They could not ask people to send records to be reviewed against a standard that they had never seen.

### OLDER PHARMACISTS AND CPD

The TREASURER (Kirit Patel) referred to the shortage of pharmacists and said that the last thing wanted was for pharmacists in upper age groups to leave the register because of a CPD requirement. What was the plan to help facilitate that group?

Dr DEWDNEY said that one thing that encouraged older members to do CPD was one-to-one facilitation sessions. They were effective but unfortunately expensive. No revalidation system would simply remove from the register those who did not meet a standard. People would be given necessary support. Next year the intention was to use the preregistration tutors as a testbed for giving feedback, because they were on an annual cycle. For those who had difficulties it was hoped to have one-to-one facilitation sessions for those who would benefit most.

Dr WILSON said that it was illogical for older pharmacists to feel that they would have to leave the profession when CPD came in. CPD started from the position that people were currently at, not the position that others thought they should be at. If they picked up their CPD activity from that point, then they were in the system.

DIGBY EMSON said that he was not opposed to CPD but he was concerned about how arduous it was to be a tutor. Were they looking at the workload of tutors in total?

Dr DEWDNEY said that the Society was concerned not to discourage anyone

from being a tutor. Therefore, it was saying: "If as a tutor you want to submit your records, we will give you feedback. If you do not want us to write to you again on that subject, we will not do so." It was entirely voluntary for the tutor. But he believed there would be some take-up.

Answering a follow-up question, Dr Dewdney said that tutors would not be required to provide facilitation. Facilitators would be recruited and trained for the role.

### WORKSHOP LOGISTICS

Mr EMSON questioned the logistics of the CPPE running workshops for 5,000 people. There might well be a focus around the north-west but where did that fit with people's CPD plans that had already been made?

Dr DEWDNEY said that there were three groups. The first group was the people in the existing pilot areas, who were already prepared. The second group was the pharmacists in the north-west, and the CPPE programme would be available to that group. They would receive the instructional video. They would also be invited to attend a workshop if they felt it would meet their CPD needs but they could not be forced to do so and a 100 per cent turnout was not expected. The third group — the tutors — was a special case. Tutors were already supported by the Society. Most importantly, they were supported in the managed service and by employers for their tutoring role.

The VICE-PRESIDENT (Dr Gill Hawksworth) asked whether the plans would be shown to the Council for information purposes.

Dr DEWDNEY said that members of Council would get sight of the video and a CPD pack. He was sure that the CPPE would allow them to see its video as well. Council members would be given user names and passwords so that they could use the user interface should they want to do so. On that user interface was a growing amount of explanatory documentation.

Asked whether any role had been considered for the Society's branches, Dr Dewdney said that they would provide an obvious focus if people wanted to get together for CPD.

ASHWIN TANNA asked when further pharmacists would be taken into the scheme.

Dr DEWDNEY said that the Society would talk to its partners, the CPPEs and the employers, before recruiting more pharmacists. The aim was a phased increase to 10,000 during 2003, but that could not be done without consulting people who bore a cost.

The PRESIDENT (Marshall Davies), thanking Dr Dewdney and Dr Wilson, said that the Government had made it clear that CPD for pharmacists would have to become mandatory. All were impressed by the amount of work that had been, and was being, done. It was a hugely important subject for the profession.

So far as Council members were concerned, the message he had clearly received was that they all, in their own particular ways, would involve themselves formally in the CPD scheme.