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THE PHARMACEUTICAL SOCIETY OF IRELAND
Cumann Cógaiseoirí na hÉireann
THE PHARMACY REGULATOR

Review of International CPD Models

Pharmaceutical Society of Ireland

Final Report

June 2010

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Foreword

Every healthcare professional, and in particular those involved in the delivery of frontline care, have a solemn duty to ensure that they are competent in their contribution to the care of patients and the public. The expectations of patients and carers that they will be provided with a safe service that delivers the best outcomes must underpin all care provision and service delivery. The principle of maintaining a level of competence sufficient to provide professional services effectively and efficiently is enshrined in the statutory Code of Conduct for pharmacists.

The challenges facing healthcare professionals in maintaining competence are considerable. The expectations of society in general, and of patients in particular, with regard to the maintenance and the development of competence is, nevertheless, the reality in which healthcare systems now function. Patients today have a better understanding of the complex care and treatment systems through the widespread availability of information through various media. Informed patients are now engaging in their own assessment of the healthcare practitioners involved in their care systems and they have access to information on healthcare performance indicators from across the globe on which to base their analysis and assessment.

A CPD system must become an integral part of a healthcare professional's practice experience. Practice must facilitate reflection on needs and on application, reflection on new approaches to care and on best practice in all healthcare settings.

The new CPD system outlined in this report that has been determined by Council of the PSI was developed on the basis of best international practice and experience and following a thorough consultation with pharmacists and other key stakeholders. There is no doubt that there is solid support for this new CPD system. Pharmacists are anxious to expand on the services they provide and to provide the best possible care to their patients and to the public.

The CPD system is mandatory for all pharmacists on the Register of Pharmacists held by the PSI. By 2014, all pharmacists will be required to be compliant. In the intervening years, the system will work with the profession to ensure an incremental roll-out for all involved and facilitate the transition to lifelong learning.

The PSI deeply appreciates the excellent work of the CPD Review Project Steering Group, the Professional Development & Learning Committee of the Council and its Chair, Dr. Paul Gallagher, who was supported by the PSI's Head of Professional Development & Learning, Ms. Lorraine Horgan.

The implementation plan and process will be established by Council in Autumn 2010. The system will be evaluated on a cyclical basis to ensure the best possible outcomes are available for pharmacists and for patients.

Dr. Ambrose McLoughlin

Registrar & Chief Executive Officer

June 2010

Executive Summary

Background to the Review

This report sets out emerging findings from the review of international models of Continuing Professional Development (CPD) across 10 geographies and 8 professions. The review was commissioned by the Pharmaceutical Society for Ireland with the following aims:

- Deliver comprehensive research and analysis of CPD models internationally
- Identify and examine, on the basis of the research findings, CPD support, assessment and audit systems for consideration in development of an Irish CPD system
- Identify appropriate means and methods for CPD delivery in Ireland, and potential provider organisations for delivery
- Distil lessons and good practice from international experience with regard to planning and rollout of CPD systems.

Countries	Sector
EU: • Finland • Ireland • Netherlands • Portugal • GB and NI	**Healthcare:** • Pharmacy • Medicine • Physiotherapy • Nursing • Radiography
Non-EU: • Australia • Canada (Ontario, British Columbia) • New Zealand • USA	**Non-healthcare:** • Accountancy • Aviation • Teaching

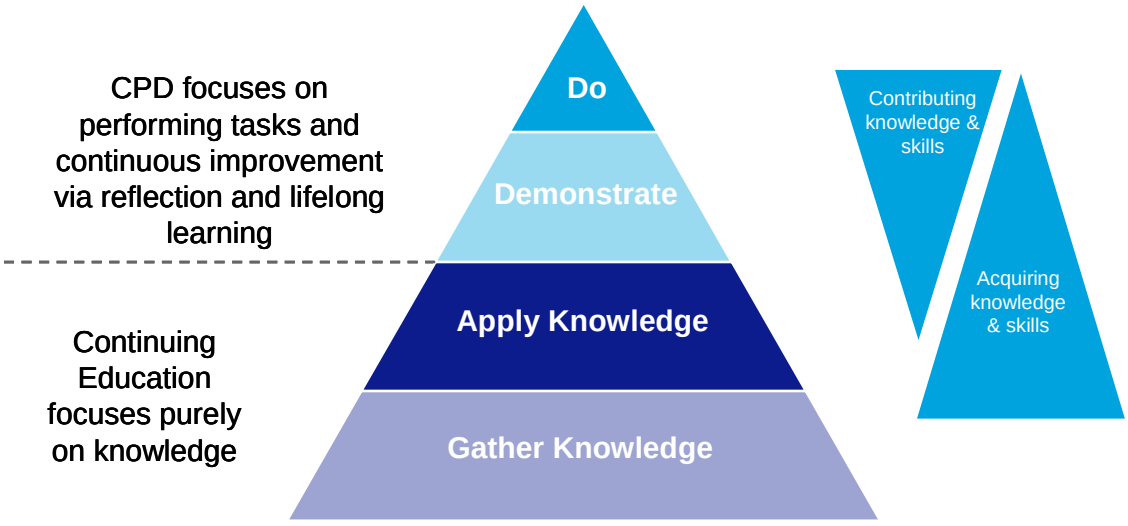
The review has involved extensive desk research on international CPD models and consultation with key stakeholders to identify the most appropriate way forward for CPD in pharmacy in Ireland.

Overview of CPD

The ultimate goal of any CPD system for health professionals is improved patient safety. An effective system should support pharmacists across a number of key areas including:

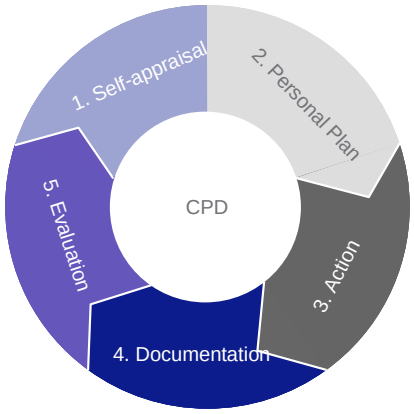
- providing patient care
- promoting health improvement, wellness, and disease prevention
- innovating and developing the role of the pharmacist
- managing and using resources of the health care system.

CPD builds on continuing education by establishing a system designed to deliver more than just dissemination of knowledge to the profession, establishing a two-way process that depends as much on the contribution of knowledge and skills by the pharmacist as formal education provision.



CPD involves an ongoing cyclical process of continuous quality improvement which allows pharmacists to learn and develop to meet their own personal and professional needs, the needs of the health service and needs of patients. It focuses on a self-directed, ongoing, systematic and outcomes-focused approach to learning and professional development.

CPD models typically involve a 4 or 5-stage model encompassing self-appraisal; personal planning; actioning activities; documenting achievements; and evaluating outcomes. Key components of an effective CPD framework include an objective standards system that clearly sets out the CPD requirements; an accreditation system that verifies the quality of CPD activity and an assessment system that verifies that professionals are meeting the CPD requirements.



A CPD system can either be voluntary, with activity undertaken as and when the professional demands it, or mandatory, where compliance is required by law or registering bodies.

Approach to Pharmacy CPD in Key Geographies

There has been an increasing trend in recent years for CPD systems for pharmacists to opt for a ***mandatory approach***. Portugal, New Zealand, Australia (4/8 states), Canada (most provinces), US (for CE) and the UK all have mandatory systems in place. The primary benefit is the assurance of a minimum level of development activity for all members of the profession, which in turn is intended to ensure a certain level of competency.

The definition of ***specific standards*** to frame CPD programmes is more varied across geographies. A range of different systems are in place, focusing on three different aspects. In Portugal there is an emphasis on standards for the CPD activities being delivered and how these link to wider learning objectives. The US has adopted a similar approach for continuing pharmacy education. Great Britain provides an example of standards that place responsibility on the professional to engage appropriately in CPD. New Zealand and British Columbia (BC) have reinforced the need for CPD to influence practice by defining prescribed competency standards reflecting the attributes required by a pharmacist to operate effectively.

Accreditation systems are usually designed and operated by the regulatory bodies (USA, Great Britain, and Australia) although the Netherlands has established a separate accreditation body to assess applications and randomly check CPD activities. While in most cases accreditation is still based on verifying the quality of CPD activities, Finland has adopted the approach of accrediting non-profit organisations to deliver CPD programmes. While accreditation in CPD remains important, there is a growing emphasis on recognition of informal CPD activities (e.g. peer networks, bitesize training courses, journal reflection) that cannot be easily accredited. The approach tends to involve identifying how these types of activities contribute to meeting overall CPD requirements. In Portugal, for example, CPD credits are awarded for attending conferences and scientific meetings and for teaching activities. New Zealand allows allocation of credits based on the outcome on practice.

Assessment systems vary but predominantly adopt a self-assessment approach, requiring the pharmacist to keep a record or portfolio of CPD undertaken which has to be submitted to the regulatory body on request (GB, Ontario, British Columbia). Australia adopts a slightly less prescriptive approach, defining an overall framework for recording and assessing CPD but not requiring this in a set format. Increasingly there is a focus on assessing the impact of CPD on practice (New Zealand, GB) with reflective online tools a key emerging trend to facilitate this – however the complexity of the system has created issues of buy-in. Most portfolio or record based systems employ credits/points/ hours based system of measuring CPD, requiring demonstration of how the pharmacist has met a minimum level of engagement (the Netherlands, Northern Ireland, BC, US. The self-assessment processes are accompanied by periodic mandatory assessment exercises in Canada, based on an examination of clinical knowledge in British Columbia, with a peer-led practice review exercise in place in Ontario. While costs inevitably constrain the extent of this sample, it must be sufficient to ensure that the expectation of external assessment motivates the professional to engage in CPD and maintain adequate records.

Other lessons apparent from the examination of international CPD models for pharmacists included:

- ***Keeping the system simple and avoiding onerous requirements***. The experience of implementing the new, outcomes focused approach in New Zealand suggested that care must be taken in placing complex recording requirements on the pharmacist or levels.
- ***Adopting an incremental approach to implementation***. A CPD system for pharmacists in Ireland represents a significant departure from the current voluntary CE engagement and it should learn from experience in geographies like Great Britain, while despite a significant period of testing and piloting the model has still struggled for acceptance and buy-in and remains confusing for the practitioner.

- ***Clear governance and management structures to ensure clarity and consistency for the professional.*** Australia is currently moving to a new single authority model for CPD in Pharmacy to add simplicity to the multi-layered and multi-state approaches in place to date. Establishing a clear CPD leadership body is an important aspect of ensuring effective development and delivery of an appropriate system.
- ***Requiring a balance of CPD activities.*** It is also important to ensure that CPD systems acknowledge the activities that are already being undertaken as part of a pharmacist's work and engagement in informal learning activities. This means going beyond the CE approaches in the United States and avoiding an overly rigid points-based system that weights CPD depending on its perceived relative importance (Portugal). An emphasis should be given to encouraging participation across a balance of activities rather than concentrating only on particular activities.

Approach to CPD in Other Professions

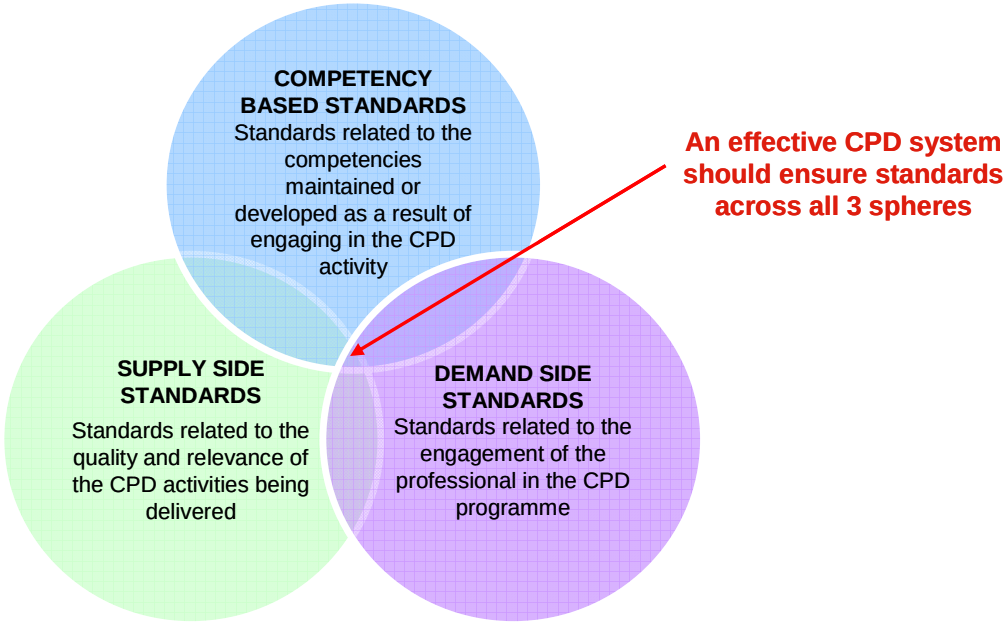
The review of CPD systems in other professions revealed a growing trend of mandatory rather than voluntary approaches to CPD, with the increasing internationalisation of professional competency standards to underpin CPD systems a further notable characteristic. For each of the models considered we can identify key learning points to help underpin development of an approach to CPD for pharmacists in Ireland:

- In ***physiotherapy***, national CPD systems and approaches are underpinned by a globally recognised framework, with CPD increasingly becoming a mandatory requirement across most jurisdictions (Ireland, UK, Netherlands, Australia, New Zealand). Learning can also be drawn from the effective deployment of web-based systems recording and assessment systems (GB, Australia)
- For ***medicine***, the development of a core competency framework by the World Health Professionals Alliance is encouraging consistency in approach across geographies in linking CPD activities to the competency of the profession. CPD is also firmly established as a professional imperative across the medicine profession in all cases.
- In ***nursing***, the inter-disciplinary focus of CPD has strong resonance for pharmacy, with the International Council of Nursing recognising and defining the key role that different stakeholders in healthcare play in the continued clinical competence of professional nurses. The CPD system currently being developed in Ireland places significant emphasis on peer and manager validation of competency, while the system in the UK requires supervisor assessment of competency as part of the CPD process.
- For ***radiography***, while participation in CPD tends to be mandatory (with the exception of Portugal) and based on assuring competency, the wider CPD system deployed in most countries facilitates practitioner development beyond generalist competency. This supports the overall evolution of the profession, a challenge for pharmacy in Ireland the midst of a rapidly changing healthcare context.

- In the ***teaching*** profession, approaches to CPD vary significantly and is not mandatory in most countries. There is a growing focus on delivering development support within the school environment, aiming to improve performance in a practical 'on the job' setting.
- The ***aviation*** profession has in place an intensive system of revalidation and re-licensing that ensures on-going commitment to CPD via a robust ongoing competency-based assessment. It is based on medical evidence, demonstration of professional flying skills and knowledge through "learning profiles checks".
- In ***accountancy*** CPD is now an integral component of every professional's working life. CIMA, the professional body for management accountants, has moved from an activity to an outcomes focused approach to CPD, with identification of expected learning outcomes prior to the undertaking of specific CPD activities.

An approach to standards, accreditation and assessment

There are three different approaches to the setting of standards related to CPD. However a successful CPD system should ***verify standards to some degree across provision, engagement and overall competency*** and this should be an aim for a new CPD system for pharmacists in Ireland.



Standards can only operate effectively if they are linked to a system of monitoring and evaluation. The recording system for CPD has been developing, with early approaches primarily based on inputs, that is, simply recording hours spent on CPD or 'points' based on hours and the nature of the activities. However there has been a growing move towards outcome-based systems of measuring CPD and this should provide a closer link to evidence which shows how practice has developed or improved due to participation in CPD. An ***outcomes-based approach to assessment of CPD should be a key objective of an Irish system*** with an overarching goal of patient safety.

The approach to audit and assessment of CPD is key to ensuring that professionals are meeting the standards and requirements set. The main monitoring systems that are currently in place are: annual auditing of a random sample of the membership; submission of a declaration of compliance on a cyclical basis; submission of a evidence in the form of records on a cyclical basis to prove compliance. Monitoring systems are inevitably highly resource intensive but are an essential component in ensuring that CPD systems remain focused on ensuring the highest quality standards in practice within the profession. The ***core ongoing assessment mechanism should place the onus on individual reflection and evaluation***, with a role for peers in supporting and reviewing experiences, and ***periodic sample assessments providing external assurance of competency.*** This assessment should be as practically focused as possible and peers again have a potentially important role to play in shaping the assessment to reflect the needs of current practice in different settings.

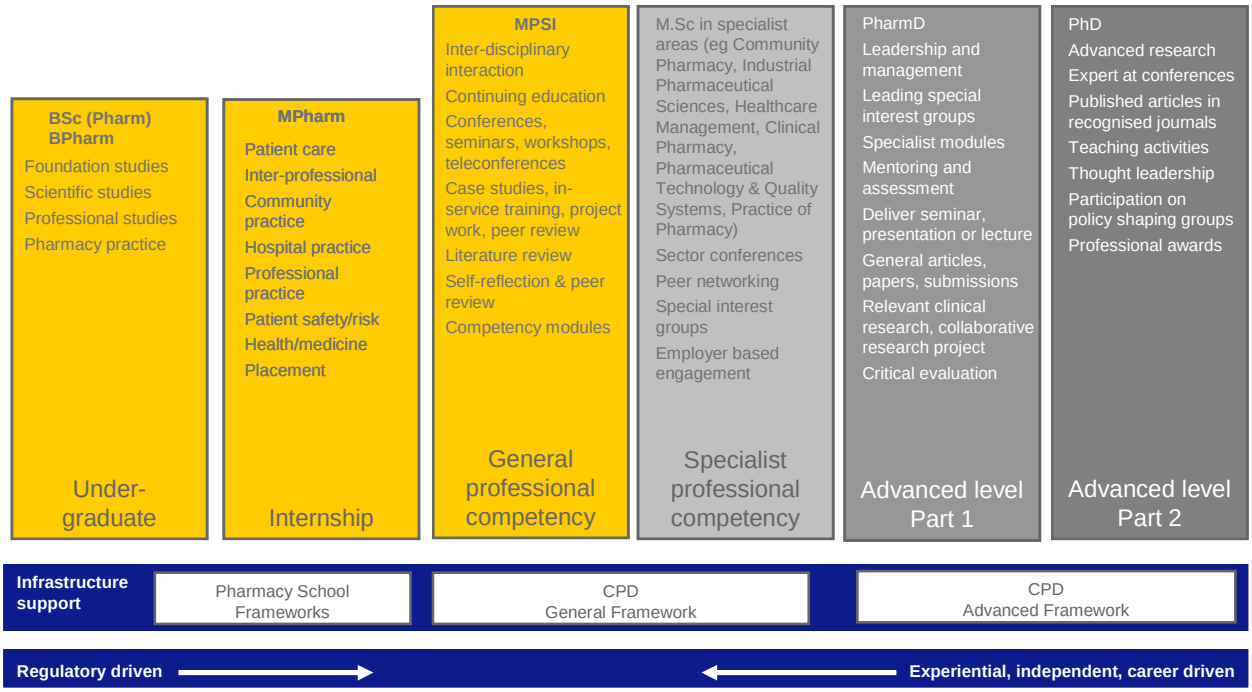
Accreditation in CPD involves the granting of recognition to an organization, site or programme that has met certain established criteria. It has involved two approaches to date: accreditation of providers and accreditation of activities. Both approaches are valid and are essential component parts in any effective CPD system. However this ***accreditation must be intrinsically linked to established supply and demand side standards*** discussed above.

Recording and measurement of CPD has tended to focus on input and outcome based approaches. The former has the advantage of being very simple to record and measure, while the latter requires more subjective judgement but does try to relate CPD activities to competencies and practice. Reflection on outcomes is important but with the increasing recognition of work-based and informal learning a points or credits based system is losing its relevance. The requirement to ***record a balance of different CPD activities in a portfolio*** should be sufficient if accompanied by a robust ***system of external competency assessment***. This assessment should be ***developed by peers*** and recreate ***patient facing scenarios*** to assess competency. A base of pharmacists should be subject to such an assessment each year, with ***coverage of the entire profession*** over a 5 year period. This assessment must be linked to ongoing registration, with a remedial process in place to help address any issues arising with regard to competency.

The CPD delivery model

Designing the delivery model for CPD must take account of the fact that pharmacists' right to practise will be derived from a ***single register system*** and that the first priority must be to ***assure competency across the entire profession***. This means that a CPD system must, first and foremost, put in place the conditions to ensure that every pharmacist in Ireland demonstrates a required level of competence.

While the initial priority must be to assure competency, the delivery model must also place ***focus on practitioner development.*** A core objective of all CPD systems is to put in place a lifecycle approach to learning that ensures the initial skills and expertise required to enter a profession are built upon continually along a defined career pathway. Over time the CPD system in Ireland should balance the need to maintain a level of generalist competency across the profession with an advanced framework designed to facilitate the pursuit of excellence and development of specialisms throughout a career.



Pharmacy is a complex profession with professionals working in very different settings that include: industry; hospital; community; and academia. ***Balancing the needs in different practice settings*** is a key challenge and one that requires recognition of the varying motivations and needs from each interest group. The central objective that links the needs in all these practice settings is the overall focus of patient safety. While it is critical to design a system that provides the flexibility for pharmacists to continually develop regardless of the environment in which they practice, the overarching driver of all activity must be improved patient outcomes.

There are many different types of activities that can contribute to CPD and a key aspect of an effective delivery model is requiring a ***balance of different CPD activities*** in a professional's development. A system that relies purely on reflection from on-the-job experiences is likely to be as limited in value as the purely educational approach. A pharmacist committed to his/her development as a practitioner should share good practice within work, network across the profession, attend relevant conferences, keep abreast of the latest research and up-skill via appropriate courses. CPD is intended to focus upon how learning is applied rather than gathered and ***placing the onus on measuring CPD outcomes*** from these activities should be a key aspect of an effective CPD delivery model.

A ***blended delivery model*** needs to be put in place that utilises available technology to its full potential. Use of e-learning to deliver CPD and interactive online portfolio and assessment tools have allowed a flexible approach to development that retains a focus on outcomes in other models. There is broad stakeholder consensus on the need for an Irish system to display such attributes and online systems should play in development of an appropriate CPD model. However, barriers around access and ICT competency mean that paper-based resources remain important in the short and medium term, and a blended model that allows use of these options is critical.

A vision and principles for the Irish model of CPD

By drawing on the research undertaken and consultation with a broad cross-section of relevant stakeholders with an interest in the development of the profession, a vision can be defined for the role of a CPD system for pharmacists in Ireland.

Vision for a CPD system for pharmacists in Ireland focused on patient safety

- A system that assures competency across the profession to meet patient needs and demonstrates this competency to others
- A mechanism to allow for innovation and development in the role of the pharmacist
- A supportive, enabling and transformative system that meets personal and professional needs
- A flexible, user-friendly and contemporaneous system that is recognised by pharmacists as helping to support the way in which they practise their profession
- A system that rewards learning by professionals and provides accreditation that is recognised internationally
- A system that encourages and supports engagement with other healthcare professionals

It is critical that the future Irish model of CPD for pharmacists is grounded in a series of core principles that make clear its purpose and relevance to the profession. These principles must be clearly communicated to all pharmacists and should serve as a central mechanism to build ownership of the system. The following core principles are proposed:

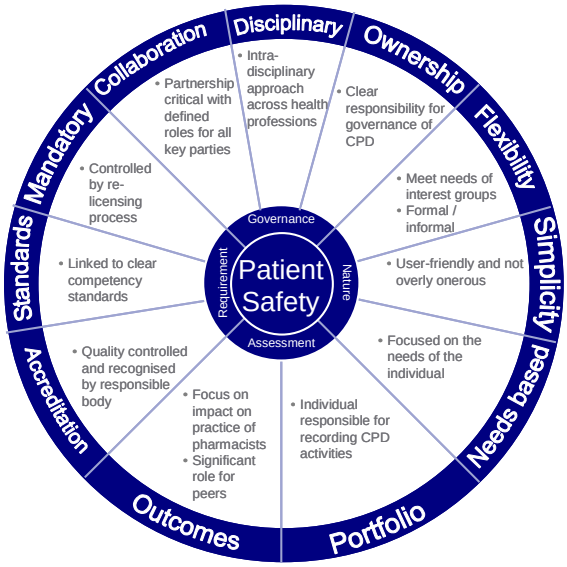
- A overriding focus on ***patient safety***, ***patient care and public welfare***
- Recognition that CPD focuses on a ***self-directed, ongoing, systematic and outcomes-focused*** approach to learning and professional development education

- Provision of a ***culture of support*** for the individual pharmacist in maintaining competence and developing as a practitioner
- ***Flexible but practical*** system with balance of learning over structure (formal, informal, etc) that demonstrates meaningful outcomes-based learner progression
- Meeting the ***needs of wider health services*** and supporting practitioner development
- Based on a ***career pathway for practitioners*** with improved patient outcomes and proven 'value-for-money'
- Ability to benefit and ***engage practitioners across all practice settings*** (including those working in community, hospital, industry and academic settings)
- ***Clarity of responsibility*** for delivering the four distinct governance functions: representing the profession; regulating the profession; accrediting CPD activity; and delivering CPD activity.
- A model ***referenced against best practice*** and based on learning from the experiences of other regulatory bodies
- ***Involvement of peers*** in the shaping of the standards and assessment systems and the CPD delivery model itself
- Engaging pharmacists by demonstrating the ***return on the investment*** of time in CPD activities.
- An approach to CPD that allows ***international recognition*** of the activities in which the pharmacist engages
- ***Appropriate resourcing*** to ensure its effective deployment

CPD must always focus on the competency of the profession. However competency is a complex construct, extending beyond skills and involving knowledge, behaviours and values and attitudes. Using learning from other CPD models and the input of the key stakeholders consulted as part of this study, we identified a series of core competencies for the pharmacy profession. Full development of a competency framework is the subject of a separate study being commissioned by the PSI.

Professional Practice	Communications and Networks	Leadership and Management	Education and Development	Research and Evidence Base	Reflection and Assessment

The competency framework, when defined, should shape the focus of CPD activities in the Irish model, with support infrastructure in place to facilitate development in each case. With the core guiding principles and the overarching professional competencies defined, a foundation is in place to develop the primary components of an appropriate CPD model for pharmacists in Ireland. Linked by an overarching goal of patient safety, the components can be broken down into four primary categories: requirement; governance; nature; and assessment.



CPD governance, management and provision

There are four important functions that make up the core components for delivery of effective continuing professional development: representing the profession; regulating the profession; accrediting CPD activity; and delivering CPD activity. While one body can be charged with responsibility for more than one of these functions (e.g. regulating and accrediting), it is critical that there is ***clear responsibility for delivering each of these four distinct governance and management functions***.

Collaboration plays a critical part in delivery of successful CPD models and mechanisms must be found to ensure that the relevant stakeholders work together effectively. Pharmacists must play an active role in identifying needs and evaluating outcomes; educators must develop skills and attitudes in students and provide continuing education; and professional bodies must support learners and provide quality assurance; employers must assure the competence of their professional staff.

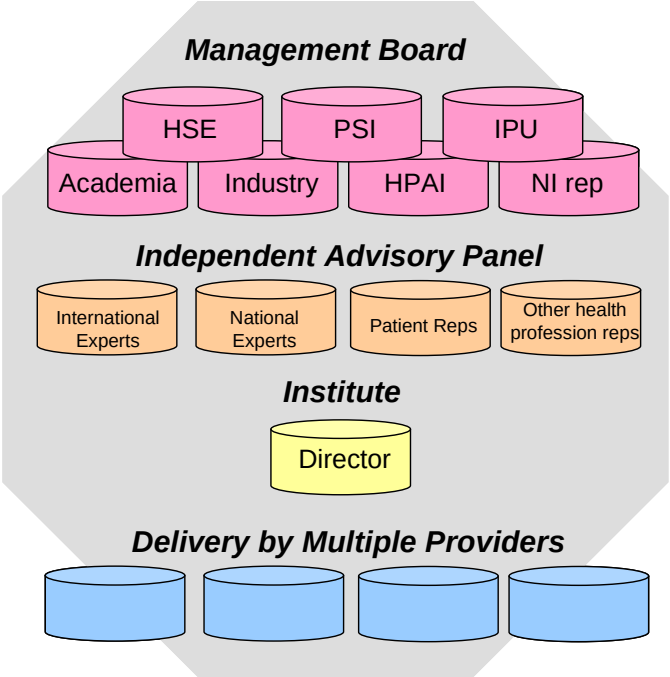
CPD funding can be provided by Government, via a membership-based system, a fee-based system or via a combination of these approaches. ***Resourcing is a critical issue that must be addressed in establishing the Irish system***, as it influences characteristics including the scale of the CPD activities that can be supported, the deployment of tools and infrastructure to support the system and the robustness of the monitoring and assessment processes that underpin its delivery.

This learning should be reflected in a robust Irish model of governance, management and provision that designates clear responsibilities for the individual functions and ensures a collaborative approach to continuing professional development and moving the profession forward. This model would involve the regulatory body ***PSI controlling the regulation and registration process and defining the competency standards against which the CPD system would be framed***. The CPD system would require a ***collaborative management structure*** that ensures buy-in and influence from all key stakeholders. The approach to provision should also ensure a ***balance of providers*** that can engage with pharmacists operating in different settings (including geographical settings) and a balance of different types of CPD activities.

Based on the research and the themes emerging from stakeholder discussions, we propose an Institute model (illustrated below). This model involves:

- A ***representative cross-section of stakeholders*** overseeing the management of the system to ensure ownership and buy-in and a ‘needs-focus’ to provision.
- An ***independent advisory panel*** (perhaps with international experts) ensuring the focus remains on patient safety via practitioner development ties
- An ***Institute overseeing the management and delivery of CPD***, funding and supporting appropriate provision and ensuring outcomes are generated by providers and assessing competency of pharmacists
- ***Multiple provider system*** in place to ensure a balance of CPD opportunities is available (including specialist opportunities) meeting the needs of pharmacists working in different settings.

Establishing an institute to be responsible for overall management, support and delivery of CPD offers clarity to the profession and a dedicated focus on driving the CPD system forward. By facilitating and quality assuring different learning models and different providers it will be able to put in place the conditions for assuring competency of the profession and supporting further practitioner development. The pharmacist would access CPD activities from providers and the importance of supporting this process at local level must also be recognised in the management of the system

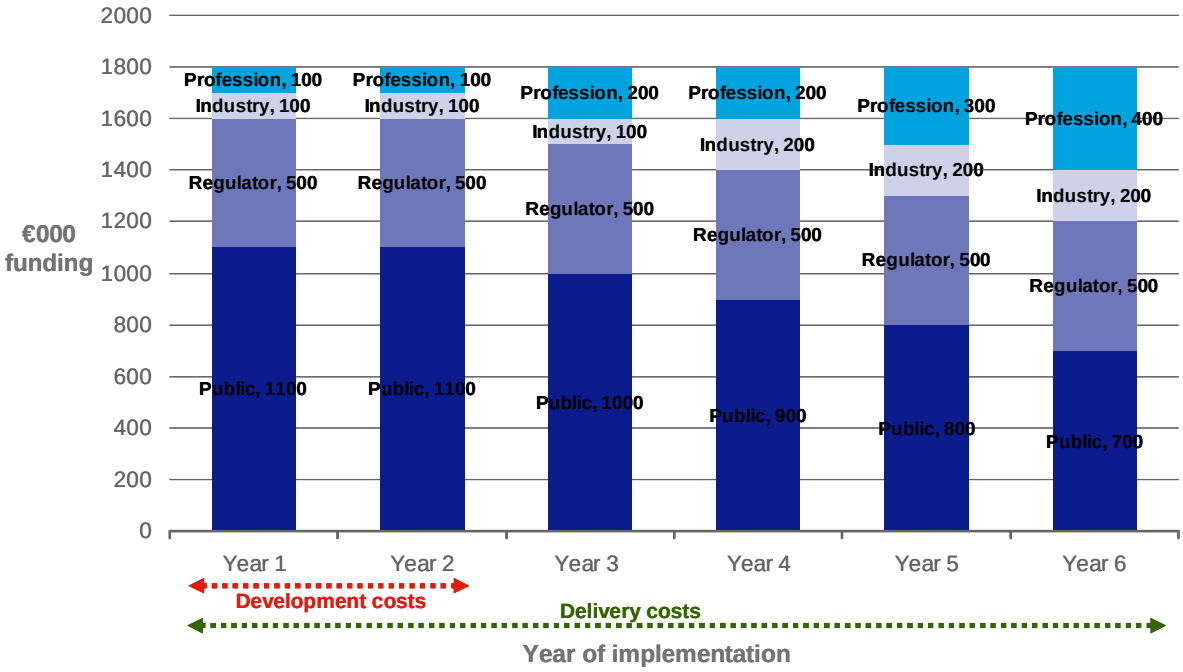


In the current environment, creating a new and additional structure is unlikely to attract any Government support. Therefore the Institute model must build on existing structures to utilise infrastructure and resources already in place. The work of the ICCPE has provided a good foundation from which to move forward, but is perceived by some stakeholders as not sufficiently independent to take on the form of the Institute. Utilising its expertise and resources within another potential structure is worthy of consideration. Any such structure should, if possible, be largely independent of any of the stakeholders directly involved in the pharmacy profession but possess the infrastructure to support this type of function (in terms of IT systems, processes, etc) and the relevant experience and expertise in CPD.

Costs and funding of the CPD system

The first step in implementing the proposed CPD system will involve full costing of the proposal, setting out the expenditure required to develop it and support delivery on an ongoing basis. The business case for investment must also be made clear in terms of assurance of competency and improved patient safety and outcomes. This should then provide a platform for funding responsibility to be established, with clarity around funding over a sustained period of time and the return on investment for each funding source.

Funding support for the CPD system should be based on principles of public investment only where there is a clear return on investment from improved patient outcomes, regulatory body investment to provide the means by which competency of the Register can be demonstrated and increased self-sufficiency by the profession in supporting the CPD system over time. Using our analysis of other models and discussions with stakeholders on potential finance available, we have constructive a suggested potential funding structure to provide a platform for further discussion, as shown in the diagram over the page.



Implementing the system

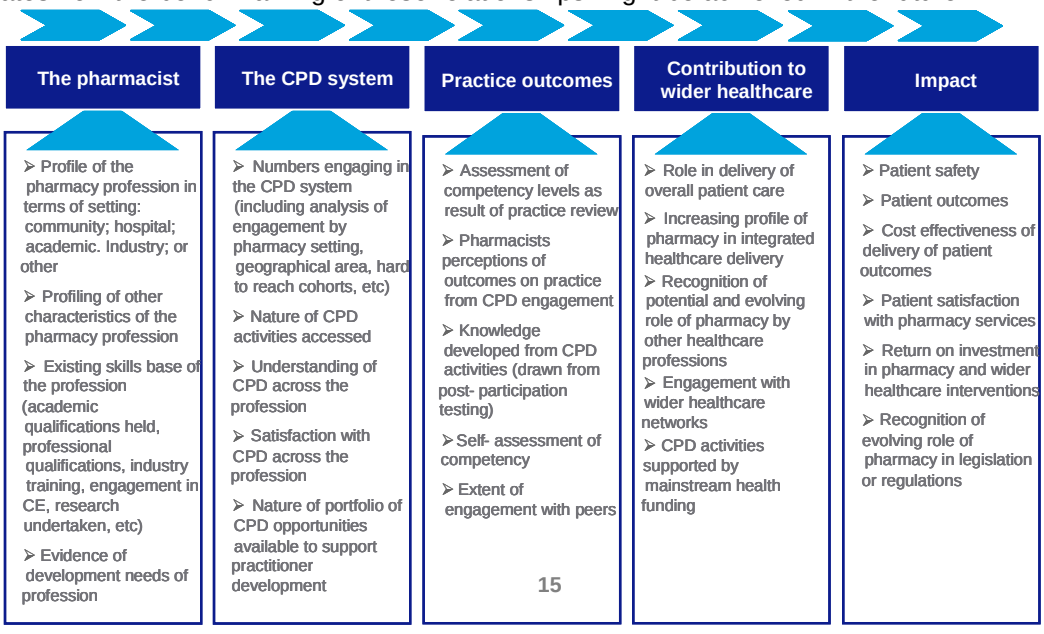
With core principles agreed and components of the new CPD system derived, the basis for effective roll-out of CPD for pharmacists is in place. Learning from implementation elsewhere demonstrates the importance of an incremental approach to adoption of the aspects that form the 'ideal' model. Trying to achieve too much too soon can alienate stakeholders and deliver an overly complex CPD process without a sufficient learning curve. An implementation plan therefore needs to be put in place that develops momentum towards full realisation of CPD vision, addressing the following themes:

- ***Establishing support infrastructure***. Support resources need to be put in place to develop understanding of CPD across the profession and the benefits it can bring. Incubator units or cell structures should also be established to bring peers together to identify any issues in the development of the CPD system prior to full roll-out.
- ***Achieving initial buy-in from stakeholders*** is pivotal to the ultimate success of the model and key to this will be a fully inclusive and meaningful consultation process that allows everyone to comment on the provisional recommendations for a new CPD system and shape the way in which it is rolled-out and delivered.
- ***Specifying the overall governance framework***, with clear communication on the role of the regulator, the role of the Institute and its representative management structure and roles and responsibilities of any other parties, with service level agreements put in place to frame these roles where appropriate.
- ***Establishing the CPD infrastructure***, involving detailed specification of the structures, tools, systems and processes required to deliver an effective CPD system. This will include detailed definition of the Institute, portfolio tools, platforms for e-learning delivery, local support structures, practice review systems, remedial processes, and so on.

- ***System development and testing.*** With the infrastructure established it is important that this is tested with a cross-section of representatives of the profession, identifying and resolving any issues over a series of iterations until systems are fully developed. The cell structures/incubation units could serve as potential mechanisms for this process.
- ***An incremental approach to roll-out***, avoiding an overly ambitious move to significant mandatory CPD requirements. A simple, step-by-step approach will secure greater buy-in across the profession. Early wins, perhaps in the form of accessible and relevant e-learning modules available via the Institute's website, should be a key initial objective in roll-out.
- ***Changing behaviour across the profession*** via promotional and educational campaigns which strongly emphasise the overriding objective of the system in improving patient safety and supporting peer engagement as a mechanism for sharing experiences, issues and ideas.
- ***Communicating the competency of the profession*** presents a final but important challenge. Part of the vision for the establishment of the CPD system is to demonstrate the current competency of the profession and the way in which this is developing to the wider healthcare sector. The pharmacy profession in Ireland is evolving at a time of significant change across healthcare and it is important that implementation of the CPD system is also used to communicate the ability of the profession to respond to, shape and drive the wider health policy agenda in Ireland.

The new CPD system and its role in improving patient safety

The pharmacy profession possesses significant expertise and experience and offers a clear contribution to securing successful patient outcomes and ensuring patient safety. An effective CPD system should harness and build upon this expertise by ensuring that practice is focused on integrated patient care, the overarching HSE goal set out in the Education, Training and Research: Principles and Recommendations report. There exists an opportunity upon the launch of a new system to benchmark and track progress in delivering such wider healthcare objectives. This should link the needs and characteristics of pharmacists to a tailored CPD framework that then helps to maintain and develop competencies. These competencies should interact with those of other professions to deliver integrated healthcare that will ultimately improve patient safety and patient outcomes. The diagram indicates how the benchmarking of these relationships might be achieved in the future.



1 Introduction

This report sets out the emerging findings of the international review of models of Continuing Professional Development across ten geographies and eight professions to provide a platform for discussion by the Steering Group. In this chapter, we detail the objectives of the review, the approach to its delivery and how the findings are set out over the remainder of this document.

1.1 Introduction

This report presents the emerging findings of the review of CPD models for the Pharmaceutical Society of Ireland (PSI). It is intended to provide a platform for discussion by the Steering Group, reflecting research and consultation undertaken and their input thus far, to facilitate further development of findings.

The Council of the PSI is seeking to develop and implement an appropriate and effective system of CPD for pharmacists in Ireland as part of its duties under the Pharmacy Act. The CPD system will underpin the professional development and lifelong learning of pharmacists in Ireland. It will aim to protect patient and public safety and generate better outcomes in terms of healthcare; maintain the high standard of the profession in Ireland and support the delivery of the HSE Transformation Programme. This review has therefore been commissioned to:

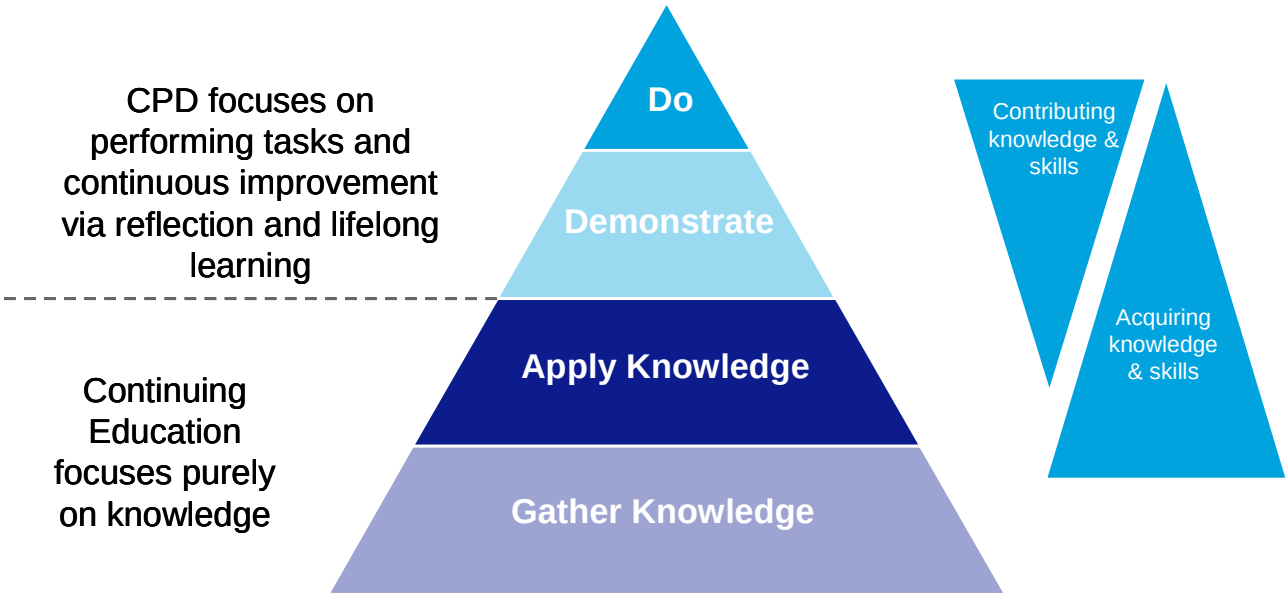
- Deliver comprehensive research and analysis of CPD models internationally
- Identify and examine, on the basis of the research findings, CPD support, assessment and audit systems for consideration in development of an Irish CPD system
- Identify appropriate means and methods for CPD delivery in Ireland, and potential provider organisations for delivery
- Distil lessons and good practice from international experience with regard to planning and rollout of CPD systems.

While the focus will be on CPD our research has also taken account of the important role that Continuing Education (CE) plays in effective CPD systems. In this regard we can also benefit from the valuable research conducted by Irish Centre for Continuing Pharmaceutical Education (ICCPE) on Continuing Education in Ireland[1].

[1] 'Pharmacy: A Report on Continuing Pharmaceutical Education in Ireland', Irish Centre for Continuing Pharmaceutical Education, October 2008.

However it must also be recognised that CPD builds on continuing education by establishing a system designed to deliver more than just dissemination of knowledge to the profession. It takes account of the skills developed within the workplace and via more informal learning activities through professional reflection. In doing so it attempts to ensure that individual practitioners are continually contributing their knowledge and skills from practice towards the overall development of the profession. This approach is illustrated in Figure 1.1 below.

Figure 1.1: CPD and Continuing Education



1.2 Our approach

This assignment combines comprehensive desk research and key stakeholder consultation to facilitate analysis on an appropriate approach to CPD in Ireland. This has involved six discrete phases of activity as follows:

- Phase 1, which clarified the scope and plan and put in place controls to ensure the assignment could be undertaken successfully
- Phase 2, which focused upon the comprehensive desk research component of the assignment, involving critical assessment of international CPD models and resulting in a comprehensive comparative analysis and supporting literature reviews
- Phase 3, which involved further research of the Irish context combined with targeted stakeholder engagement to test the applicability of international models to Ireland
- Phase 4, which reviewed appropriate methods of delivery of CPD, as well as the identification of potential suitable providers
- Phase 5, which focused on implementation, including the lessons learnt from the experience in other countries, as well as the identifications of key areas for planning and action in Ireland

- Phase 6, which brought together the outputs of all the previous phases for discussion by the Steering Group. This allowed overall findings to be developed and agreed and this final report to be produced.

The international research focused on comparator CPD models for pharmacists across 9 countries (and 10 geographies given that British Columbia and Ontario were identified as having relevant but differing systems in Canada) and 8 other relevant professions. These were agreed with PSI and are shown in Figure 1.2.

Figure 1.2: Countries and Sectors Under Review

Countries	Sector
EU: • Finland • Ireland • Netherlands • Portugal • Great Britain and Northern Ireland	**Healthcare:** • Pharmacy • Medicine • Physiotherapy • Nursing • Radiography
Non-EU: • Australia • Canada (Ontario, British Columbia) • New Zealand • USA	**Non-healthcare:** • Accountancy • Aviation • Teaching

1.3 In this report

The remainder of this report is structured as follows:

- Chapter 2 considers the legislative context behind the establishment of a CPD system.
- Chapter 3 provides an overview of CPD.
- Chapter 4 examines the approach to CPD for pharmacists in key geographies.
- Chapter 5 considers CPD systems in other professions.
- Chapter 6 identifies learning from the approach to standards, accreditation and assessment in other CPD models.
- Chapter 7 discusses the implications of our research for the delivery of CPD in Ireland.
- Chapter 8 sets out a vision and core principles for the development of an appropriate CPD system for pharmacists in Ireland.
- Chapter 9 considers the governance, management and provision mechanisms that will have to be put in place to effectively support a CPD system

- Chapter 10 considers the high-level implications of the proposed CPD system for costs and funding.
- Chapter 11 sets out themes to frame the roll-out and implementation of a CPD system.
- Chapter 12 outlines the wider context of the role of a new CPD system in improving patient safety and how this can be benchmarked moving forward.

2 The Legislative Context

In this section we consider the legislative context behind the introduction of a CPD system for pharmacists in action. The Pharmacy Act defines the responsibilities of the PSI in relation to CPD and ensuring professional competence. Alongside other legislation, its sets out a clear requirement for an appropriate approach to CPD moving forward.

2.1 The Pharmacy Act 2007

The Pharmacy Act 2007 (the Act) establishes the statutory responsibility of the PSI for education, training and lifelong learning (including CPD) for pharmacists on behalf of Irish patients. In this regard the regulator must ensure that all pharmacists have the knowledge, skills and competencies to meet the needs of patients and health services (both Irish and EU), now and in the future.

The Act specifies the requirement for engagement in CPD by registered pharmacists in defining the principal functions of the PSI. From the 22nd May 2007, the PSI is required to:

- Promote and ensure a high standard of education and training for persons seeking to become pharmacists
- Ensure that those persons and pharmacists obtain appropriate experience
- Ensure that pharmacists undertake appropriate continuing professional development, including the acquisition of specialisation.

The Act establishes the overall responsibility of the regulator in determining and applying the criteria for registration and to draw up codes of conduct for pharmacists. The PSI is also charged with the determination, approval and review of programmes of education and training suitable to enable persons applying for registration to meet those criteria and pharmacists to comply with those codes. A further duty is the taking of suitable action to improve the profession of pharmacy.

In framing the powers of the PSI, the Act provides for the PSI to:

- Conduct or arrange for the conduct of examinations of persons who are applying or might apply for registration.

Under ancillary powers further defined by the Act, the PSI is entitled to carry out or commission research into and evaluation of education and training (including the formulation and testing of experimental curricula) and examination and assessment processes in relation to pharmacy and it is by virtue of this provision that this report has been commissioned by the PSI.

2.2 Other legislative requirements relevant to CPD

Other secondary legislation derived from the Pharmacy Act 2007, impact upon the potential functioning of a CPD system. The Pharmaceutical Society of Ireland (Retail Pharmacy Businesses) (Registration) Rules 2008, which came into effect on 29 November 2008, require all pharmacy owners to supply a statement, as part of the application to register a retail pharmacy business, on the arrangements put in place for continuing professional development, including continuing education, in respect of all registered pharmacists employed or engaged in the retail pharmacy business. These arrangements must ensure that those pharmacists ***"obtain and maintain appropriate experience in the practice of pharmacy, and undertake appropriate continuing education and continuing professional development with a view to protecting, maintaining and promoting the health and safety of the public."***

Introduced in tandem with the registration rules, the Regulation of Retail Pharmacy Businesses Regulations 2008 place further responsibility on the pharmacy owner and the superintendent pharmacist to ensure that "he or she is satisfied that all of the pharmacists and other staff, employed or engaged by him or her, or under his or her management, have the requisite knowledge, skills, including language skills, and fitness to perform the work for which they are, or are to be, responsible"

The responsibility of employers, pharmacy owners and superintendent pharmacists to ensure that pharmacists and other staff have the required level of skills and knowledge has implications for the way in which the CPD system is designed and established. In effect, the legislation is providing for employers and pharmacy owners to be an integral part of the CPD system, which should provide a framework by which this responsibility can be discharged. It provides a potential platform to ensure that the staff for which they are responsible engage in the CPD system, and the support and controls in place for pharmacist participation in CPD should reinforce their ability to achieve this.

The Pharmaceutical Society of Ireland (Registration) Rules 2008, which also came into effect on 28 November 2008, require each pharmacist, when applying for continued registration, to detail how he/she ensures both the maintenance of appropriate experience in the practice of pharmacy, and the keeping abreast of continuing education and CPD.

This latter power is important to the dynamics of any new CPD system for pharmacy. It allows the regulator to request records detailing engagement in CPD activities as part of its consideration of applications for continued registration on the Register of Pharmacists. The CPD system can facilitate such requests.

2.3 The code of conduct and maintaining competency

The Pharmacy Act 2007 also requires the PSI to draw up codes of conduct for pharmacists, which may also be linked to fitness to practise and professional misconduct where breaches are apparent. The statutory code of conduct for pharmacists was approved by the Minister for Health and Children on 14 November 2008 and laid before the Houses of the Oireachtas in February 2009. Aspects of the code of conduct include:

- Every pharmacist is personally responsible under the Code of Conduct for his/her own acts or omissions
- Pharmacists may also be responsible under the Code for the acts or omissions of persons operating in the area of pharmacy under their direction, control or supervision
- Applies to all pharmacists irrespective of form of professional practice

The onus on personal responsibility and application to all settings of pharmacy practice is important in the design of a CPD system which must echo these characteristics. Central to the system must also be a strong focus on ensuring competency, reflecting the fifth principle of the code of conduct. This states that a pharmacist must maintain a level of competence sufficient to provide his/her professional services effectively and efficiently. It means that the individual pharmacist has responsibility for maintaining competence, engaging in ongoing audit, review and learning and communicating effectively. It is important that a CPD system plays a role in supporting this process. To fulfil their obligations under the Code, it states that a pharmacist should, among other things, maintain, develop and update competence and knowledge of evidence-based learning, which includes CPD and continuing education.

3 Overview of CPD

In this chapter we provide an overview of Continuing Professional Development, highlighting the aims and objectives of its introduction and defining the overall nature of CPD approaches. We then discuss the CPD cycle, the core components of a CPD framework and its role in both mandatory and voluntary systems.

3.1 Aims and objectives of CPD

The ultimate goal of any CPD system for health professionals is improved patient safety:

> "Maintaining competence throughout a career during which new and challenging professional responsibilities will be encountered is a fundamental ethical requirement for all health professionals. Patients have a right to be confident that professionals providing health care remain competent throughout their working lives. They will expect governments, accreditation agencies and other pharmacy bodies with a legitimate interest, to seek assurances that regulatory bodies are taking the necessary action to achieve this goal."[2]

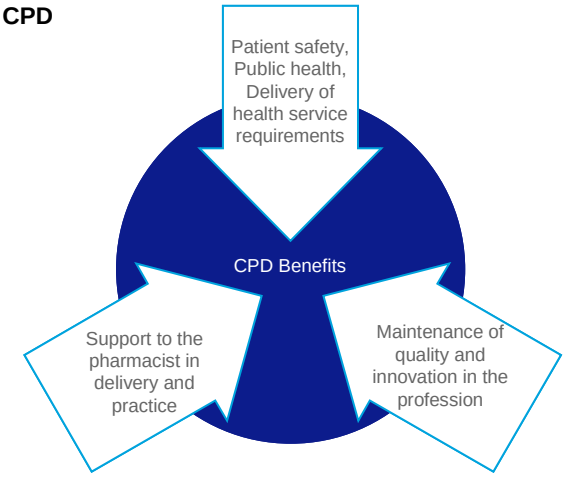
Pharmacists must keep up to date with changes in pharmacy practice, the law relating to pharmacy and the knowledge and technology applicable to pharmacy, and must maintain competence and effectiveness as a practitioner. CPD supports pharmacists in:

- Providing patient care
- Promoting health improvement, wellness, and disease prevention
- Innovating and developing the role of the pharmacist
- Managing and using resources of the health care system.

Some of the key benefits of CPD for pharmacists are highlighted in Figure 3.1.

[2] Protecting the Public FIP Statement of Professional Standards: Continuing Professional Development (2002)

Figure 3.1: Benefits of CPD



3.2 Definition of CPD

There are a variety of different definitions used for continuing professional development across different jurisdictions but must of these definitions share a set of common characteristics. Continuing Professional Development is an *ongoing cyclical process* of *continuous quality improvement* which allows pharmacists to *learn and develop to meet their own personal and professional needs*, the *needs of the health service* and *needs of patients*. CPD is generally a *self directed process* that enables individuals to develop and enhance a broad range of knowledge, skills and attitudes relevant to their *existing and future* roles.

It is important to differentiate CPD and Continuing Education (CE). The latter can be defined as structured learning experiences and activities in which pharmacists can engage after they have completed their academic education so as to improve knowledge, skills and competencies. Comparatively, CPD requires pharmacists to take personal responsibility for the identification of their learning and development needs and, importantly, for subsequent evaluation of their success in meeting those needs. In CPD, CE is just one component of the learning experiences in which pharmacists are being encouraged to engage.[3]

CPD is focused on the individual practitioner; CE is structured to address the learning needs of the majority of practitioners. One of the reasons for the shift towards CPD is the limited effect of formal CE activities on the behaviour of the practitioner[4][5]

[3] Global Pharmacy Workforce and Migration Report, International Pharmaceutical Federation (FIP), 2006

[4] International Trends in Lifelong Learning for Pharmacists

[5] Use and effectiveness of pharmacy continuing education materials, Vittorio Maio, Dea Belazi, Neil I. Goldfarb, Amy L. Phillips and Albert G. Crawford. American Journal of Health-System Pharmacy, August 2003

CPD is currently an issue that is under the spotlight and many national bodies are seeking to reform and improve their approach to CPD in order to ensure that the professionals operating in those sectors are engaged in a process of ongoing maintenance and growth of professional excellence through participation in accredited lifelong learning activities. There is currently a global shift in place as many professional bodies are moving from a fairly limited Continuing Education based approach to a much more comprehensive Continuing Professional Development approach. As highlighted earlier in Chapter 1, there are important distinctions between continuing education and continuing professional development, and indeed with lifelong learning. These terms are often used interchangeably but the difference in the individual definitions is highlighted in Figure 3.2. [6]

Figure 3.2: Continuing Education, Continuing Professional Development & Lifelong Learning Definitions

Term	Definition
Continuing Education:	A structured process of education designed or intended to support the continuous development of pharmacists to maintain and enhance their professional competence. Continuing education should promote problem-solving and critical thinking and be applicable to the practice of pharmacy.
Continuing Professional Development:	A self-directed, ongoing, systematic and outcomes-focused approach to learning and professional development. CPD includes but goes beyond CE.
Lifelong Learning:	All learning activity undertaken throughout life, with the aim of improving knowledge, skills and competence, within a personal, civic, social and/or employment-related perspective.

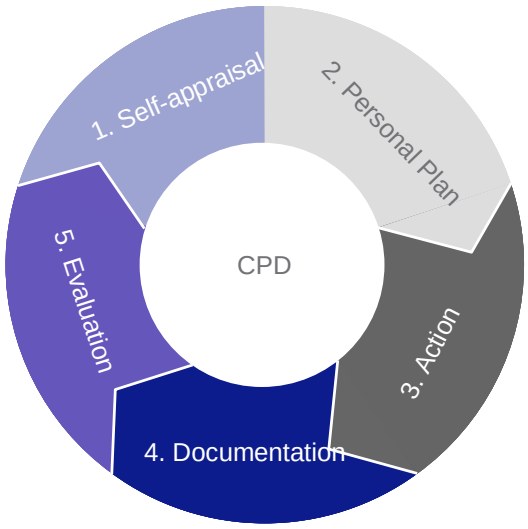
Despite a general recognition that the CE approach is not sufficient for changing the behaviour of pharmacists, the shift towards CPD has been slow in many countries. A number have moved into a legal framework of mandatory CPD in recent years: Portugal (2001), France (2002) and the UK (2004). However the complexity of CPD, as well as each country's traditions, experiences, and environmental influences can make it difficult to implement the CPD approach. Therefore, although some countries have adopted the philosophy of CPD, they continue to use typical CE elements such as the credits system. These mixed systems appear to offer scope for greater control by regulatory organisations, a feature which is inherent to CE, as well as a framework for pharmacists that enables sustained behaviour change, which is inherent to CPD.

[6] http://www.farmasi.uio.no/vett/Jubileum/Silva.pdf

3.3 The CPD Cycle

The design principles of each of the CPD models that we have examined through our research are based on the CPD cycle, a 4 or 5-stage cycle from self-appraisal to evaluation and back to self-appraisal. Some models include documentation as a separate step in the process, where as others include it implicitly in the overall process. We adopt the former approach in Figure 3.3, which shows the five stages to the Continuing Professional Development cycle.

Figure 3.3 Continuing Professional Development Cycle[7]



Key Steps in the CPD Cycle

1. Self-appraisal to identify the learning need;
2. Personal plan to plan how to achieve improvement;
3. Take action by engaging in appropriate CPD activities;
4. Document action to record achievements;
5. Evaluate the outcomes.

In progressing through this cycle, there are a number of key features of CPD that frame the delivery of effective programmes:

- It is based on the pharmacist's self-identified learning needs, not those identified or imposed externally;
- CPD is self-directed, requiring the learner to demonstrate motivation and responsibility for his/her learning;
- CPD is linked to needs within the practice itself (ie, issues that arise out of the unique features of the individual's practice context e.g. community, hospital, research/academic);
- Outcomes (in terms of maintenance of competence, professional development, and the meeting of individual or organizational goals) frame the entire process.

7 American Journal of Pharmaceutical Education 2005; 69 (1) Article 4. Continuous Professional Development: A Qualitative Study of Pharmacists' Attitudes, Behaviors, and Preferences in Ontario, Canada Zubin Austin, PhD,a Anthony Marini, PhD,b Nora Macleod Glover, BSP,c and Della Croteau, MCEdc

3.4 Key components of a CPD framework

Most systems of CPD are underpinned by a defined framework which specifies the core components of the model. The World Health Professional Alliance has played a global leadership role in this regard, establishing a framework which has been built upon in national CPD systems, such as the 'Enhance' programme for pharmacists in New Zealand and 'Mainpro' framework for medics in Canada The aim is to design and implement a CPD framework that is fit for purpose, that is not overly onerous on participants or administration, that represents value for money in relation to the cost of setting up and running the system and that will achieve the goals of delivering ongoing improvements in service delivery.

Although the detailed implementation of the CPD varies, the key components of the system are common across all places:

- An objective **standards system** that clearly sets out what the CPD requirements are, details the minimum requirements for registration or membership, defines the scope of activities, determines what unit will be used to measure CPD and explains any calculations involved in quantifying CPD;
- An **accreditation system** that verifies that the standard and quality of CPD events, material and literature is adequate, fit for purpose and will help to deliver improved quality of service for clients, customers or patients;
- An **assessment system** to verify that members, registrants or license holders are meeting their professional development requirements

Although the exact definitions and interpretations of CPD may vary somewhat across sectors and geographies, there is also evidence of strong commonalities and overlap. The internationally recognised approach is that CPD is seen as a lifelong process that aims to update or enhance existing knowledge to refine existing skills, and to develop the appropriate values to enable and support the delivery of professional practice.

3.5 Mandatory and voluntary CPD systems

There are two basic approaches to the requirements for CPD placed upon the profession. The approach to CPD is defined as mandatory if compliance is required by law or registering bodies. It means that a professional can only continue to practice if he/she demonstrates the required level of CPD engagement. In a voluntary system participation in CPD is optional.

The 2006 Global Pharmacy Workforce and Migration Report[8] found that of the 37 countries surveyed, just 9 had mandatory systems of CPD while the remaining 28 did not have any mandatory system in place. In recent years, many European countries have established means of assuring pharmaceutical competence via legal frameworks for compulsory CPD. Portugal (in 2001), France (in 2002) and UK (in 2004) all took this step. GB and Portugal also have fully mandatory CPD systems in place for pharmacists, as does Ontario and New Zealand. Other geographies, including British Columbia and Australia, operate a voluntary CPD system. We will detail the nature of these mandatory and voluntary systems in Chapter 4. Most of the other professions that we have examined also have a system of mandatory CPD (e.g. medicine, aviation, accountancy) and the nature of these systems are further discussed in Chapter 5.

An effective CPD system provides a transparent, clear and systematic process for ongoing education and development of professionals. Some of the key advantages of a mandatory approach to CPD are discussed below.

- One of the key principles of Continuing Professional Development is that **it is self-directed**. Although the CPD framework might be a mandatory system, most CPD models incorporate sufficient flexibility for the professional to evaluate and determine their own learning needs and to design an appropriate response to those needs in a way that is targeted, specific and accessible for the participant. This approach allows participating professionals to focus specifically on what they need to do to remain competent and stay up-to-date.
- CPD **provides employers with a structured framework** for developing and harnessing the potential of their employees. While structured career development pathways may be established by some large employers, many pharmacists working in community pharmacies or as part of a small pharmacy team may not benefit from this structured approach to career development. Mandatory CPD provides a tool for structuring, managing and developing a professional's career based on their own assessment of their learning needs.
- Mandatory CPD also **assures the general public as well as relevant industry or public bodies** and any other relevant stakeholders that a certain level of competence is required for professionals to continue to practice in their particular field. It ensures that their skills are up-to-date and being refreshed on an ongoing basis and that they are abreast with the latest industry and technical developments relevant to their sector.

Thus, if a mandatory system of CPD is implemented in a way that is user-friendly, accessible and not unnecessarily onerous for professionals, it provides a useful, transparent accountability tool for the professional, their practice, the government and the general public. It will confirm that the professional has engaged in a programme of ongoing learning and development and is therefore competent to deliver the appropriate services.

[8] International Pharmacy Federation, Global Pharmacy Workforce and Migration Report, 2006

The voluntary system of CPD does not place prescriptive requirements on the professional to participate. This has the advantage of ensuring buy-in by those that do engage in CPD, rather than a system where professionals are attending due to obligation, with the risk of them having limited motivation to learn. However the voluntary approach is only effective if it can attract a significant base of the profession in participation, and this means making clear the benefits of involvement. For example, in Finland, demonstrating engagement in CPD is a criteria in the competitive licensing process. In Australia, CPD is a means of confirming commitment to professional standards, which is a requirement of registration.

3.6 Implications for the Irish CPD system for pharmacists

In considering the approach to CPD for pharmacy and for other healthcare professions across international models all are linked by one shared overarching goal: to improve patient safety. This should be the starting point for definition of an appropriate Irish model of CPD. A number of other implications for the Irish model can also be derived from examination of approaches in other models and these are summarised below:

- The Irish CPD system should support pharmacists in providing patient care; promoting health improvement, wellness, and disease prevention; and managing and using resources of the health care system.
- The design and development of the system should be based on the premise that Continuing Professional Development is an ongoing cyclical process of continuous quality improvement. The system should be designed to allow pharmacists to learn and develop to meet their own personal and professional needs, the needs of the health service and needs of patients. It must build on approaches of continuing education by focusing on a self-directed, ongoing, systematic and outcomes-focused approach to learning and professional development.
- The CPD system should encompass elements of self-appraisal; personal planning; actioning activities; documenting achievements and evaluating outcomes in line with the 5 stage model typical in the other CPD systems considered.
- An effective CPD framework for the Irish system should include an objective standards system that clearly sets out the CPD requirements; an accreditation system that verifies the quality of CPD activity and an assessment system that verifies that professionals are meeting the CPD requirements.
- There are both voluntary and mandatory CPD systems in place across the international models considered, although there is a growing trend for the latter approach. For pharmacy, an effective CPD system provides a clear benchmark to determine competence for the professional, a structured training scheme for employers and assurance for the general public and relevant industry or public bodies. We consider it important that Ireland adopts a mandatory approach in the development and implementation of a CPD system for pharmacy.

4 Approach to pharmacy CPD across key geographies

In this chapter, we present a summary of the approach to CPD in pharmacy in each of the geographies researched. This begins with an overview of all the systems currently in place, followed by more detailed discussion on the nature of the system and their approach to standards, accreditation and assessment.

4.1 Comparison across geographies

In the previous chapter we provided an overview of the key characteristics of CPD models. We now present our research into individual CPD systems for pharmacists by nationality, based on a combination of literature review and consultation with key stakeholders with an interest in each system. The central purpose of this research is to facilitate comparison across the models and identify learning that can influence the development of an appropriate and effective CPD system for Ireland. In Figure 4.1 we provide a broad overview of the characteristics of each national system(s) for this purpose, with the remainder of the chapter dedicated to examination of each system in greater depth.

Figure 4.1: Comparison of CPD Systems Across Geographies

Geography	System	Funding	Standards	Accreditation	Assessment
Portugal	Mandatory renewal process for a professional license every 5 years, which includes statutory requirement to demonstrate engagement in CPD	Costs of CPD activity primarily paid for by pharmacist at point of participation	Standards in place to quality assure CPD activities with strong focus on demonstration of how outcome from activity influences practice	Accreditation focuses on the CPD activity and the provider – streamlined system in place to assist accreditation of the latter	Professionals assessed in terms of CPD credits gathered every 5 years. Failure to show 15 COD credits results in remedial process

Australia	Mandatory systems requiring proof of CPD in 4 of 8 states, moving to single registration and regulation system by Pharmacy Board of Australia in July 2010	PSA provides CPD as member benefit from overall fees. Federal and state health departments also fund initiatives	Standards in place for individual in recording CPD and structured approach to improving competency via the CPD&PI	Accreditation of an activity in Australia lasts 3 years and involves review of both quality of education and relevance to practice	Onus on individual to maintain portfolio of CPD activity which is periodically assessed Self-assessment tool allows pharmacists to assess in core areas.
New Zealand	Mandatory system in place since 2006 with re-registration every 5 years. Replaced voluntary system in place since 2001	Largely funded by membership contributions of the professional body with some additional Government support	Competency standards in place to define the skills, knowledge and attitudes required of a pharmacist	Only one CPD programme accredited to date with pharmacists allocating credits to each activity based on the outcome it had on their practice	Evidence of outcomes credits from CPD has to be submitted on request. Mandatory self-assessment every 5 years
Canada	Mandatory in most provinces in Canada and is regulated by the provincial pharmacy boards. Re-registration based on practice review and portfolio. Key role for peers	Combination of Government and Regulator funding support for CPD system, while pharmacists also typically pay a fee at point of participation	NAPRA Framework of Professional Practice provides a detailed, comprehensive description of pharmacy practice and serves as the standards of practice	CPD can be accredited on individual programme basis or via an accredited provider. Accreditation based on expert review and learning review panel. CCCPE national accrediting body	On-going cycle of self-assessment in Ontario and BC. In Ontario, all pharmacists have to keep a learning portfolio that must be submitted on request. Significant role for peer review

US	Model of mandatory CE across all 50 states based on regular re-licensing. CPD system piloted across 5 states.	Approach differs across states but generally paid for by the pharmacist either at participation or on membership basis	Accreditation Council for Pharmacy Education (ACPE) recently revised its standards for continuing pharmacy education (CPE).	ACPE accredits CE providers, rather than individual CE activities. Involves Colleges of Pharmacy (ACCP), professional body and regulator.	Completion of a learning assessment is required for a CPE credit. Must demonstrate specified number of hours of approved/accredited CE to renew license
Great Britain	Mandatory for all pharmacists to enrol in Plan and Record CPD Framework	Combination of Government support and pharmacist contribution via a membership fee which allows access to all CPD resources	Standards for engagement in CPD system introduced for pharmacists on the 1st of March, 2009. Ni prescribed standards for CPD activities	No requirements on type of CPD activities that participants must report, as long as they contribute to the professional development.	Every CPD entry documented in a portfolio in line with CPD cycle. RPSGB request CPD records for review, typically every 3-5 yrs.
Northern Ireland	Devolved bespoke system. CPD a professional requirement for all pharmacists since 2005. PSNI currently seeking the legislation from DHSSPS to make continued registration a statutory requirement.	Government, regulator and profession all contribute to costs of CPD, the latter via a membership fee Grant schemes to access courses also available	Standards based on requirements for engagement of the professional in CPD. Categories of CPD activity that are eligible are stipulated.	PSNI formally accredits activities, with NICPLD the main provider for live and distance learning opportunities for pharmacists registered in Northern Ireland	Required to complete a self-declaration form stating that they have undertaken 30 hours of CPD for annual registration. Random selection must submit evidence/portfolio, with four possible graded results (Options 1-4).

Netherlands	Effectively mandatory system in place via controlled through health insurance system	Funding provided by professional bodies for CE programmes	No formal standards but cross-professional approach ('BIG' law) to ensuring maintenance of competence	Separate accreditation body assesses applications and randomly checks CPD	Input based approach to measurement of CPD based on number of hours. Demonstration of 40 hours CE linked to re-registration process
Finland	Mandatory requirement to update professional knowledge introduced in 2006. Strong collaboration model.	Government funding of CPD programmes, with pharmacists required to pay a fee to participate. Also uses pool of industry funding to support delivery	Linked closely to address the community pharmacy strategy and key healthcare priorities	Non-profit organisations accredited to deliver CPD activities. Professional bodies also accredited to deliver CPD	Compulsory professional development programmes that must be completed by pharmacists

The individual systems in place in each of the geographies are discussed in further detail in the sections below. For each system, we outline its mandatory or voluntary nature and its approach to standards, accreditation and assessment.

4.2 Portugal

The Portuguese Pharmaceutical Society (Ordem dos Farmacêuticos) is the regulatory and licensing body for the pharmaceutical profession in Portugal.[9] It began implementation of its Continuous Education Programme in 1983 and has responsibility for defining standards for and accrediting CPD activities. The National Association of Pharmacies (ANF) represents the interests of the legal owners of community pharmacies. A range of bodies, including higher education institutes, can deliver CPD activities, as long as these have been fully accredited. The sectoral split across the profession involves 55% of practising pharmacists working in community pharmacies, 11% in clinical biology, 8% in hospital pharmacy and 6% in industry.

[9] www.ordemfarmaceuticos.pt

4.2.1 Nature of the system

The PPS has established a mandatory renewal process for a professional license every five years, subject to a pre-defined number of credit units (15) obtainable through CPD activities[10]. This has a statutory basis, with the new statute of the PPS was passed into law by the Portuguese parliament in November 2001[11]. This was the first time that engagement in Continuing Professional Development (CPD) became a legal pre-requisite for the revalidation of the right to practise. The vast majority of formal accredited CPD activities are funded by the professional at the point of participation.

4.2.2 Approach to standards

The Portuguese approach to standards is focused on quality assurance of the CPD activities provided, with particular focus on how the outcomes from engagement will influence professional practice. Types of relevant CPD activities are defined, with an emphasis on formal education on initial establishment in 2001. However in 2009 the Portuguese Pharmaceutical Society introduced some changes to appropriate activities, with more focus on recognising engagement with the profession via meetings and networks. Each CPD activity is subject to a standards based evaluation of its quality and relevance by the PPS. Standards relate to the definition of learning objectives, programme content and nature and quality of educators and applicability and relevance to practice.

4.2.3 Accreditation of CPD

Accreditation is linked to the standards for CPD activity noted above and also to the providers of that activity. Each CPD activity is accredited by PPS, with a requirement to submit a detailed programme of provision, detailed CVs for each individual responsible for its delivery and the education materials used. The CPD activity is also weighted in terms the CPD credits allocated to the professional for engagement. A general system of categorisation of CPD activity is in place that frames the allocation of credits in this way, as shown in Figure 4.2. This also provides flexibility to allocate credits to other types of activity provided an outcome in terms of professional practice can be demonstrated. However it still restricts such activities to formal learning activities, with no system in place to recognised work-based and other forms of informal learning, which can in many cases have the most critical impact on professional development.

Figure 4.2: Accreditation of CPD Activities by Category in Portugal

Category of CPD activity	CPD credits allocated
Continuing Education courses	1h = 0,10 CPD credits
Participation in congresses, symposiums and other scientific meetings	1h = 0,1 CDP credits

[10] 6th Internaional Conference on Life Long Learning in Pharmacy "Continuing Professional Development – The Portuguese Experience", Fernando Ramos, Vice-President; José Aranda da Silva, President; Tania Saraiva, Professional Secretary of the National Board; Ivana Silva, Professional Secretary of the National Board; Portuguese Pharmaceutical Society Lisboa, Portugal

[11] The Pharmaceutical Act, Decree-Law 288/2001, Government of Portugal, November 2001

Post Graduation courses	1h= 0,1 CDP credits (max. 5 CPD)
MsD	10 CPD
The PPS Specialist title, PhD or other academic graduation	15 CDP
Teaching activities (educators) – only considered within the scope of the 'pharmaceutical act'	1h = 0,2 CDP (max. 2 CPD/ activity)
Other Activities	Evaluated case by case

Continuing Professional Development activities are provided through professional associations, pharmacy schools and other universities. Providers are accredited in line with their ability to deliver a recognised and approved CPD activity and are required to complete a quality certificate. There are currently 115 organisations accredited to deliver CPD activities. PPS has recently launched a new online portal[12] that allows registrants to manage their Continuing Professional Development portfolio. The new system aims to reduce the bureaucracy involved in the process of applying for accreditation of training activities and provides a list of all accredited training bodies.

4.2.4 Assessment process

The revalidation model of pharmacist competency was defined following the legislation of 2001 based around ability to demonstrate engagement in sufficient CPD activity (on the basis of accumulated number of credits) over a five year period. Implementation of the system began in 2004, with a first group of 1,950 pharmacists. The society has continued to carry out revalidation assessments for around one-fifth of the profession in each year since, establishing an assessment cycle that allows full coverage of the profession in this process. Pharmacists who fail to demonstrate accumulation of 15 CPD credits face remedial action, which may require undertaking of an extensive examination to maintain a license to practice. Failure to demonstrate competency may result in disciplinary action and ultimately suspension from practice[13].

[12] www.ordemfarmaceuticos.pt/foramacaocontinua

[13] "Global Pharmacy Workforce and Migration Report", International Pharmaceutical Federation (FIP), 2006

4.3 Australia

The CPD system in Australia for pharmacists is currently undergoing a process of significant change. Currently there is a registering authority in each state and territory of Australia (Pharmacy Boards for New South Wales, the Northern Territory, the Australian Capital Territory, New South Wales, Victoria and Tasmania and the Pharmaceutical Society of Western Australia) responsible for registration and regulation of pharmacy within that jurisdiction. The Australian Pharmacy Council is the national body overseeing the registration processes of these authorities and aims to promote consistency across the profession, with specific responsibility for accrediting continuing professional development activity and assessing the competency of overseas pharmacy graduates wishing to register in Australia. However on 1 July 2010 these registering authorities will be decommissioned and all registration and regulation issues will be the responsibility of the newly established Pharmacy Board of Australia. Registrants will then have national registration that enables them to work anywhere in Australia.

The Pharmaceutical Society of Australia (PSA) is the national professional pharmacy organisation representing approximately 75% of pharmacists in Australia[14]. The PSA has a dual function: supporting pharmacists' commitment to high standards of patient care and continuing professional development; and representing their roles as frontline health professionals. The PSA provides initial and ongoing education, training and practice support for pharmacists and pharmacy staff as part of this role. The Australian Pharmacy Council has assigned responsibility to the PSA for accreditation of CPD across the profession to the PSA.

4.3.1 Nature of the system

The regulatory authorities at state and territory level aim to ensure the ongoing competence of pharmacy registrants. Completion of CPD delivered by an accredited provider will be recognised by these authorities as an indicator of effort to maintain competence and, where appropriate, to satisfy re-registration requirements. Since 2007, four of the country's eight jurisdictions require pharmacists to show proof of their involvement in lifelong learning activities. Victoria, New South Wales, Australia Capital Territory, Tasmania and South Australia all require some degree of ongoing CPD and Queensland is introducing mandatory CPD from 2010. The introduction of the Pharmacy Board of Australia is expected to lead to a mandatory CPD system with a common registration process across Australia.

[14] Website: www.psa.org.au

The system has a clear diving line between regulation and registration and the development, accreditation and delivery of CPD, with responsibility for the latter assigned to the professional body - the PSA. The PSA define the framework for CPD, accredit CPD activities and deliver some of these activities themselves, although other delivery agents are also accredited. Nevertheless the introduction to a Pharmacy Board and related developments in standards and accreditation discussed below responds to the need for a more consistent system with cross-state responsibility. It should also offer a simpler approach to governance that will be easier to understand for the professional.

The funding of CPD activities involves a combination of sources. PSA provides much of the CPD portfolio as a member benefit to pharmacists, using membership fees to support costs. However there are also initiatives by other accredited providers that are paid for by professionals at the point of participation. Federal or State health departments also support a range of CPD activities.

4.3.2 Approach to standards

Although each jurisdiction determines how their respective lifelong learning requirements are to be demonstrated, all recognise the standards developed by the PSA in their recommended frameworks for recording of CPD and delivery of the Continuing Professional Development and Practice Improvement programme (CPD&PI). The PSA guiding principles for participation in CPD include:

- Participants are self-motivated and actively participate in identifying their own learning needs and assessing their achievements.
- Participants have preferred ways of learning and assessing their performance and must therefore have choices available to them.
- Learning opportunities that are relevant to the needs of the individual participant's practice will be most valued.

The PSA's CPD&PI programme provides a structured approach for pharmacists to improve competency and quality for the benefit of the pharmacist, their patients and the general community. The programme incorporates a number of tools, including:

- **The Essential CPE Modules:** The CPE modules provide updates on a specific disease and its current management or an area of particular therapeutic interest to pharmacists. Successful completion of the assessment in the Essential CPE module awards members with six credit points.
- **ProMed Pharmacy** is the online education programme specifically for pharmacists and it is accredited with the CPD&PI programme. The Primed Pharmacy collection presents a wide range of interesting and informative topics and updates on medicines and diseases, community pharmacy and pharmaceutical treatments.

- **The Australian Pharmacist** is published monthly and it contains Continuing Professional Development opportunities for PSA members related to the topical articles of the issue. Three CPD&PI credit points are available for successful completion of the education programme via the online answer sheet which can be submitted online, via post or fax.[15]

The PSA's framework for recording CPD is based on a weighted credit points system, allocating greater value to more effective educational activities. The PSA also have a role in providing activities that can be incorporated into the CPD programmes of individual states.[16]

4.3.3 Accreditation of CPD

As noted above, the Australian Pharmacy Council authorised the Pharmaceutical Society of Australia to accredit providers of Continuing Professional Development. As part of the move to assign all responsibility for registration and regulation to the Pharmacy Board of Australia, the Australian Pharmacy Council has been assigned the accreditation functions for pharmacy under the National Registration and Accreditation Scheme, which will be introduced on the 1st of July 2010. This is the natural extension of the work by the APC in recent years to developing a common system of accreditation across all Australian states.

The accreditation of an activity in Australia involves review of both quality of education and relevance to practice. It assists pharmacists to identify opportunities that best address their own professional competence.[17] The PSA will accredit CPD providers as well as continuing to deliver its own CPD programmes. Accreditation is provided for a three-year timeframe and quality assurance audits are carried out during that time to ensure that accredited providers are meeting their requirements on an ongoing basis. The PSA has recently reviewed and updated all accreditation criteria and procedures. Since the 1st of January 2009, all CPD activities were required to meet the *Criteria for the accreditation of activities for Continuing Professional Development and Practice Improvement*[18].

4.3.4 Assessment Process

CPD credit points are awarded for a range of activities including participation in workshops and seminars, online training, survey participation and training certificates. The onus is on the individual to maintain a portfolio of CPD activity and this is periodically assessed in the four of the eight jurisdictions that require demonstration of involvement in lifelong learning activities. For example, the Pharmacy Board of Tasmania has in place the following approach to ongoing assessment:

- Completion of an annual Statutory Declaration of Competency, based on an assessment by each pharmacist of his/her own competency in his/her particular area of practice.

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[15] Website: www.australianpharmacist.com.au

[16] "International Trends in Lifelong Learning for Pharmacists", Annelies Driesen, PharmD, Koen Verbeke, PhD, Steven Simoens, PhD, and Gert Laekeman, PhD, Am J Pharm Educ. 2007 June 15; 71(3): 52.

[17] "Strategic Plan 2008—2010", Australian Pharmacy Council, 2007

[18] 'Criteria for the accreditation of activities for Continuing Professional Development and Practice Improvement', Pharmaceutical Society of Australia, 2009

- To assist in this self-assessment, a Personal Audit of Basic Competency tool is in place with a simple checklist-based system that assesses competency against the 8 basic units in the Competency Standards published by the Pharmaceutical Society of Australia (PSA).
- Maintenance of a professional portfolio providing evidence of how pharmacists have maintained their competence to practice.
- An audit of a random sample of 10% of pharmacists to ensure that the evidence contained in their portfolio is sufficient to demonstrate how they have maintained their competence.

This is assisted by the provision of a self-assessment tool, the Gold questionnaire, which allows pharmacists to self-assess in core areas of drugs, disease state management and pharmacy practice. Successful completion of this self-assessment exercise itself awards participants with ten credit points to count towards their CPD obligations under the programme. This is a key aspect of the Australian system, with assessment of this kind and testing linked to CPD activities bringing additional credit points – thus achieving a balance between inputs (i.e. points for participation in CPD) and outcomes (i.e. the learning achieved via the CPD). By encouraging self-assessment in this way, but stopping short of making it obligatory, it is encouraging a focus by the pharmacist on maintaining and building competency. As Australia moves to a single regulatory and registration authority, it will be able to link a common system of assessment to overall registration of pharmacy. The existence of these tools to assess competency provides an opportunity to directly link registration to competency levels in the future, building on the balanced approach to assessment in place.

4.4 New Zealand

Of all the international models, New Zealand has progressed the most radical and outcomes-focused approach to continuing professional development. The concept of CPD was introduced to New Zealand as early as 2001, with a voluntary pilot programme that ran for four years. The programme requirements were finalised in 2005 and made available to all New Zealand registered pharmacists, although initially on a voluntary basis. This long lead in time to full roll-out of the system allowed the outcomes arising from different types of activities to be explored, particularly in terms of how CPD linked to maintenance and development of competency.

The resultant system has placed a significant onus on pharmacists identifying and validating outcomes, particularly in terms of work-based assessment, and in theory it represents the ideal application of CPD as a tool for driving the development of professional competency. However in practice there is some concern that it can place overly complex responsibilities on the individual pharmacists, with lack of clarity and difficulties in overcoming the assessment process making it difficult to engage the entire profession in the way envisaged. In the first full CPD audit undertaken, approximately one half of pharmacists were asked to provide extra evidence. This was significantly higher than anticipated during the design of the scheme and suggests either a lack of understanding of requirements or a lack of compliance. As a result of this, the CPD auditing process is taking up more resources than anticipated.

This is perhaps a lesson that Ireland must guard against being overly ambitious within a short period of time, concentrating first of all on bringing along the hardest to reach groups to engage in simple forms of professional development, rather than expecting full roll-out of an intricate outcomes-based system immediately.

4.4.1 The nature of the system

The Pharmacy Council of New Zealand was established under the Health Practitioners Competence Assurance Act 2003 and is responsible for registration of pharmacists, the setting of standards for pharmacists' education, scopes of practice and conduct. The Council introduced a mandatory system of CPD in April 2006. A series of benefits were set out on commencement that the Board wished to realise as a result of the mandatory system for the public, the pharmacist and the wider profession. These benefits are summarised in Figure 4.3.

Figure 4.3: Intended Advantages of the New Zealand CPD System

Stakeholder	Advantages
The public	• Assurance that there is a competent pharmacy workforce • Improved pharmaceutical care, resulting in improved health outcomes • Consistency of pharmaceutical care by pharmacists throughout the country
The pharmacist	• Provides a clear benchmark to determine competence • Provides assurance of competence • Helps pharmacists to identify learning needs and to plan CPD that maintains and supports their practice
The profession	• Describes the unique role of the pharmacy profession in the provision of health care • Provides direction to providers of CPD activities • Provides assurance to the profession of quality as a whole • Enables the professional body to continue to support pharmacists in initiatives that meet the changing health needs of the public

The main outlet for CPD in New Zealand is via the ENHANCE programme which is largely funded by the membership contributions of the professional body, the Pharmaceutical Society of New Zealand (PSNZ). This programme is free to members of the PSNZ or can be accessed by non members for an annual fee of $395 per annum. Government provides some support for the costs of this programme and other development initiatives in support of wider healthcare objectives.

4.4.2 Approach to standards

The Pharmaceutical Society of New Zealand introduced competence standards to define the skills, knowledge and attitudes required of a pharmacist practicing in New Zealand[19]. A competency-based pre-registration programme was introduced in 1997 to ensure that all new pharmacists entering the Register of pharmacists had been assessed as meeting the competence standards. The standards define the minimum competencies for entry to the profession and for maintaining competence through assessment of pharmacists' practice against the standards set. The seven competence standards are:

- Practice pharmacy in a professional manner
- Contribute to the quality use of medicines;
- Provide primary health care
- Apply management and organisational skills
- Research and provide information
- Dispense medicines
- Prepare pharmaceutical products

The Competence Framework is defined by these seven standards set for pharmacists, with each standard listing the knowledge, skill and attitude needed to be competent in that particular area. Participants are required to collect evidence against each standard to determine and demonstrate competence.

4.4.3 Accreditation of CPD

The approach to accreditation in New Zealand differs from other models due to the focus on outcomes rather inputs, thus allowing more flexibility around the activities that generate the outcomes. New Zealand's Pharmacy Council has adopted a single programme approach to accreditation, with the only intervention formally accredited being the Pharmaceutical Society of New Zealand's (PSNZ's) Enhance CPD programme. The Enhance programme was launched to provide a framework for implementation of the new standards, but was not a prescribed programme of activities in line with those that other CPD models accredit.

Participation in Enhance has been mandatory part of the re-registration process since March 2006. It obliges the pharmacist to pursue a 4 step programme to CPD as follows:

- ***Step 1 – Reflect***, which involves determining which competence standards are relevant to practice, assessing competence against the Competence Standards and identifying CPD needs.
- ***Step 2 – Plan***, requiring development of identified CPD needs into learning plans
- ***Step 3 – Action***, where the planned learning is implemented

[19] Pharmaceutical Society of New Zealand. ENHANCE. Available at: http://www.psnz.org.nz/public/enhance/what_is_enhance/Enhance.aspx.

- ***Step 4 – Outcomes***, with the outcomes of learning evaluated and documented and the cycle continued

This system is unique in that it is not based on a traditional input credit points system. Instead, the PSNZ developed an outcome credits system in which pharmacists allocate credits for a CPD activity based on the outcome it had on their practice.[20] However this has created problems of disengagement as it requires a significant change of behaviour on the part of a pharmacist used to an approach of continuing education. The lack of accreditation and quality assurance of CPD activities means total reliance on the individual pharmacist to accredit each activity by reflecting on the impact on practice. However this does not ensure a balance of different CPD activities and risks the real skills developed from the system revolving around ability to articulate improvements in practice rather than changes in competence levels themselves.

4.4.4 The assessment process

Assessment of continuing competence began in July 2001 with the launch of the Enhance programme. Three scales were developed together with guidelines to assist pharmacists in allocating the appropriate number of credits to their CPD activities. Upon request, evidence to support the outcomes of their CPD has to be submitted. Apart from the CPD requirements, pharmacists also have to complete a self-assessment on competences every five years, unless they change their area of practice, in which case, another self-assessment against the Competence Standards must be taken.[21] While self-assessment is a critical aspect of any effective CPD system and a link to competency standards is also pivotal, the lack of a prescribed balance of CPD activities or inputs allows too much flexibility for the pharmacist and does not facilitate a robust assessment of practitioner development. A similar approach is adopted for initial registration as a pharmacist, meaning that competencies used in the pre-registration process map to those used to frame practice post-qualification.

4.5 Canada

Canada provides interesting examples of how a CPD system can be established that ensures levels of generalist competency without placing overly onerous requirements on the individual pharmacist. It has achieved this in a variety of ways including the deployment of peer involvement to validate competency (as, for example, in Ontario) and use of e-learning to improve access to CPD opportunities (as, for example, in British Columbia).

[20] "Approaches to Continuing Professional Development (CPD) Measurement", International Accounting Education Standards Board, Information Paper June 2008

[21] "International Trends in Lifelong Learning for Pharmacists", Annelies Driesen, PharmD, Koen Verbeke, PhD, Steven Simoens, PhD, and Gert Laekeman, PhD, Am J Pharm Educ. 2007 June 15; 71(3): 52.

It also has organisational structures in place that help to ensure a consistent approach to CPD across the country. Each provincial regulatory authority manages CPD, with the National Association of Pharmacy Regulatory Authorities acting as voluntary umbrella body. The Canadian Council for Continuing Education in Pharmacy (CCCEP) is a national organisation established to accredit continuing pharmacy education programmes intended to be delivered to pharmacy professionals in more than one province. In the following paragraphs we will consider the approach to CPD Canada-wide and in the individual provinces and territories. As required by the terms of reference for the review, the research will particularly concentrate on Ontario and British Columbia as detailed examples.

4.5.1 The nature of the system

Pharmacy CPD is mandatory in most provinces in Canada and is regulated by the provincial pharmacy boards. Pharmacists are generally required to participate in CPD in order to maintain their license to practice. Most territories and provinces have some form of mandatory CPD credits. Ontario has a mandatory learning portfolio with no mandatory credit level, while other areas, such as British Columbia and Alberta, have a mix of mandatory CPD credits and self-directed learning.

Each province or territory has its own regulation/registration body for pharmacy practice. The Ontario College of Pharmacists (OCP) takes on this role in **Ontario**. It has in place a mandatory Quality Assurance Programme consisting of a two-part registration system, a learning portfolio, and a practice review process with remediation. The function of the Register is to distinguish between pharmacists active in direct patient care (part A) and in non-direct patient care (part B). Regardless of their status, all pharmacists have to keep a learning portfolio to demonstrate lifelong learning. This documents their self-identified learning needs, activities, and outcomes.

In **British Columbia**, the College of Pharmacists of British Columbia (CPBC) is responsible for making sure every pharmacist is fully qualified and able to provide the public with competent care. CPBC launched the Professional Development and Assessment Programme (PDAP) in September 2003 as part of their legislated mandate to offer a flexible quality assurance programme.

The system for delivery of CPD activities also varies depending on pharmacist need. **British Columbia** covers a significant area with a large number of relatively isolated practising pharmacies across the geography. There has therefore been a strong emphasis on use of innovative technology and e-learning approaches to engage with a wider base of the profession. Initiatives have included three University of British Columbia (UBC) Continuing Pharmacy Professional Development conferences designed, developed and delivered “live” in the Vancouver, BC location. For each of the conferences, multimedia presentations were digitally recorded in “real time” and later converted into viewer-friendly, streaming web lectures using innovative technology. The presentations, which are accessed on the UBC Continuing Pharmacy Professional Development website, are now available to BC pharmacists as a pilot project, with the objective of determining the level of interest in, and the perceived value to, this form of distance learning. Based on the feedback received to date, this learning format has been very well received and its use will be further rolled out.

Funding of the CPD system in **Ontario** involves the support of the registration and regulatory body, the College of Ontario Pharmacists, for the development and maintenance of tools to facilitate CPD, including recording and assessment. The actual CE and CPD activities are delivered by a range of providers and attract Government support when aligned with wider healthcare objectives. There is also an onus on the professional to pay for access to such activities. A similar approach to funding is adopted in **British Columbia**, with the College of Pharmacists of British Columbia, the regulatory body, supporting the costs of the tools and assessment systems to facilitate the CPD process. CPD and CE activities then tend to be accessed by the professional on a participation fee basis.

4.5.2 The approach to standards

The approach to standards varies depending on the approach of the regulatory and registration body in each territory or province. At national level, the CCCEP uses a defined set of ***standards for CPD activities*** which define whether an activity can be recognised as contributing to professional development. The standards require a focus on active and/or interactive learning activities to assist learners with knowledge transfer into their practice; encourage working in partnership with established pharmacy organisations in development and delivery; demonstration of assessment of the learning needs of the target audience; and a strong programme evaluation component.

At territory or province level the approach to standards can vary, but regulatory bodies have put in place ***competency standards*** to frame the development of CPD. In **British Columbia**, the PDAP highlighted above is underpinned by the Framework of Professional Practice (FPP), which provides a detailed, comprehensive description of pharmacy practice in BC and serves as the BC standards of practice. The FPP provides the foundation for College programmes and services and the College of Pharmacists of British Columbia. It describes the standards the college uses to assess the quality of pharmacy practice and provides a basis for current and future practice support initiatives. The FPP is designed to help pharmacists enhance their practice and patient outcomes and guide their professional development. The FPP is used by individual pharmacists, teams, managers and the college in a variety of ways, as shown in Figure 4.4.[22]

Figure 4.4: Benefits of the Framework of Professional Practice in British Columbia

Stakeholder	Benefits
Pharmacists	• Evaluate ways of working • Assess practice outcomes, knowledge, skills and abilities • Develop a practice enhancement or professional development plan • Communicate more effectively with colleagues and clients
Teams	• Review ways of working • Identify gaps in practice or services to clients • Clarify work roles and responsibilities

[22] British Columbian College of Pharmacists, Framework of Professional Practice, 2006 http://www.bcpharmacists.org/library/D-Legislation_Standards/D-2_Provincial_Legislation/1009-FPP.pdf

	• Highlight professional development need • Generate and provide feedback
Managers	• Improving recruiting and hiring • Provide employee feedback and training • Develop job-specific training programmes • Foster team development • Enhance communication with other departments and external agencies
The College	• Recognise practice excellence • Guide quality assurance programmes, including the Professional Development Assessment Plan

4.5.3 Accreditation of CPD

Accreditation at national level is the responsibility of the CCCEP as part of its overall role "to advance pharmacy practice through quality continuing pharmacy education". A programme accredited by CCCEP is recognised by all provincial regulatory authorities. A number of key drivers underpin the accreditation process as follows:

- Providing pharmacy professionals with a dependable basis to select quality CPD programmes;
- Enabling uniform assignment of CPD credits;
- Promoting the standardisation of CPD that augments the delivery of enhanced pharmacy practice.

CCCEP accredits continuing pharmacy education activities by either accrediting the provider or the individual programme. Provider organisations are accepted on the basis that they are federal, provincial or territorial organizations which support the purpose and objectives of CCCEP and are involved in the regulation or provision of continuing professional development for pharmacy professionals. Individual programme accreditation involves two phases:

- The ***expert review phase*** is conducted prior to the programme's submission to CCCEP for accreditation. The purpose of the expert review is to determine the accuracy of the content of the programme and is completed by experts in the field.
- The ***learning review panel*** phase is a peer-review process, with pharmacy practitioners reviewing each programme and making recommendations on accreditation. The panel are asked to rate the relevance of the learning material to pharmacy practice; the overall learning experience and educational value; whether the presentation of content in the programme is balanced and free of bias. For independent study programmes, they also provide an assessment of the contact hours for the purpose of assigning CEU credits (Independent study programmes only). There are five members on each panel that reviews an Independent Study Programme and three members on each panel that reviews a live programme. An effort is made to have members of each Learning Review Panel from different areas of practice (community, hospital, industry, etc.) and from different parts of the country.

Following the conclusion of the review process, a provider or sponsor who is dissatisfied with the accreditation decision of the CCCEP may submit an appeal of the decision in writing to the Executive Director of the CCCEP. The accreditation of a provider by the CCCEP allows an organisation to accredit their own programmes using the CCCEP Guidelines and Criteria for Accreditation for Continuing Pharmacy Education Programmes.

CPD programmes can also be accredited by the provincial regulatory authorities but this process also tends to be consistent with the CCCEP approach. In **Ontario**, the Ontario College of Pharmacists follows CCCEP guidelines to evaluate and accredit continuing education programmes. In order for a CE programme to be considered for listing on the College's website, advertised in the College's publication, Pharmacy Connection, and assigned Continuing Education Units (CEUs) by the OCP, an accreditation form must be completed and assessment by the College conducted.

In **British Columbia**, the CCCEP system of accreditation is followed and Continuing Education Units are accepted as part of the CPD system. Between August 2007 and August 2009, an option of engaging in a CE-plus system was available that considered non-accredited activities and the nature of assessment in this regard is further considered in section 4.5.4.

4.5.4 The assessment process

While the approach to accreditation of continuing education has been increasingly standardised through CCCEP, the approach to assessment is more varied across territories and provinces.

The system in **British Columbia** is currently in a process of review. As noted above, CPD is framed by the Professional Development and Assessment Programme (PDAP) and based around a fixed 5 year cycle that was due to end in September 2009, with a new programme launched simultaneously. However the launch of the new PDAP has been delayed to allow for full review of the programme and a new pilot initiative introduced during its delivery, CE-Plus, by the Board of Examiners. The Board is due to make recommendations within the next month on how the future programme should be delivered.

All registered pharmacists are required to participate in PDAP once every six years. As part of an on-going cycle, one-half of registrants participate at a time by first completing a self-assessment based on the FPP and then by selecting one of two assessment options to demonstrate that they meet the BC standards of practice. Registered pharmacists must participate in a periodic standard self-assessment exercise based on the FPP and then select one of two assessment options - Knowledge Assessment (KA); or the Learning and Practice Portfolio (LPP) - to demonstrate that they meet the BC standards of practice. These assessment exercises must be completed at least once every 6 years with two delivery cycles in place covering one-half of the profession each time. The KA and LPP assessments can be summarized as follows:

- **Knowledge Assessment:** An open-book multiple choice examination of clinical knowledge. The KA is based on the framework of professional practice and as such focuses on the application of knowledge and skills needed to solve drug-related problems and provide direct patient care. The KA includes questions that relate to therapeutics, pharmacology and ethical-legal issues.

- **Learning and Practice Portfolio:** An easy-to-follow format that helps pharmacists to plan, implement and evaluate their professional development and link it directly to their practice. The LLP allows pharmacists to determine what they want to learn, how they want to learn it, and how the new learning will affect their practice.

Pharmacists who successfully meet the standard on either assessment option during Phase 1 are considered to have satisfied CPD requirements for that six year cycle. Those that do not meet the standard during Phase 1 are given another opportunity in Phase 2 to demonstrate that they meet the standards of practice. Pharmacists who do not meet the standard in Phase 2 receive individual remediation and support to help them undergo reassessment during Phase 3.

The CE-Plus system was piloted within the PDAP and offered as an option to participating pharmacists. It represented an attempt to acknowledge that CPD could go beyond formal educational activities and attempt to recognise more informal and work-based learning alongside courses or workshops that had been accredited and granted CEUs. Offered as an option within the PDAP, to satisfy CE-Plus requirements, the learning must be directly linked to at least one role in the Framework of Professional Practice (the competency standards discussed above). Participants are required to log at least six learning records and a minimum of 15 hours of learning per year. CE-Plus recognises all kinds of professional learning, including, but not limited to:

- Accredited courses offered by post-secondary institutions and accredited training bodies through multiple modes, e.g. in-class, online, distance learning, etc.
- Advanced practitioner courses
- In-service learning activities: work-based information-sharing and discussion (i.e case studies, discussion groups, journal clubs, rounds)
- Articles, journals, videos, books
- Conferences

The future of the CE-Plus approach will become clear following the Review of the Board of Governors. However there are mixed reports concerning its effectiveness, with a lack of clarity around the benefits of different types of learning (and the reliance on self-assessment to measure outcomes) leading to doubts that there has been a positive impact on practice.

In **Ontario**, as part of the Ontario College of Pharmacists Quality Assurance Programme, pharmacists are required to complete a self-assessment exercise at least once every five years, although an annual undertaking is encouraged. The self-assessment tool requires pharmacists to self-assess themselves against the profession's standards, rate their clinical knowledge and create a learning plan.[23]

[23] International Trends in Lifelong Learning for Pharmacists, Annelies Driesen, PharmD, Koen Verbeke, PhD, Steven Simoens, PhD, and Gert Laekeman, PhD, Am J Pharm Educ. 2007 June 15; 71(3): 52.

The maintenance of a CPD portfolio recording the learning undertaken provides ongoing recording and assessment. While a record of learning can be maintained in any format, the Ontario College of Pharmacists encourage use of a Learning Portfolio which is available online from their website. The portfolio documenting CPD activity must be submitted to the regulatory authority upon request.

In addition, randomly selected pharmacists complete a Self-Assessment Survey. This allows the Ontario College of Pharmacists to better understand pharmacists' learning needs and activities across the province. Randomly selected pharmacists also complete a three-part practice review process where feedback is provided on their knowledge and skills. For some, remediation via peer assistance may be required.[24]

Indeed, the role of peer review is particularly important in the assessment process in Ontario. The Ontario College of Pharmacists have established a peer review process that involves a clinical knowledge and practice based assessment for around 240 pharmacists per annum. The peers who serve as assessors in this process are fully trained for their role and are sourced from a cross-section of pharmacy settings. Delivered over an intensive 6 hour period, the assessment of the pharmacist covers a number of components including:

- A **learning portfolio sharing** session where the pharmacist discusses CPD activities and learning outcomes with their peers.
- A **clinical knowledge assessment** involving review of 20 cases (focusing on relevant, common situations for the pharmacist) with an open book multiple choice test related to each.
- **Standardised patient interviews** focusing on gathering information from patients and patient management and subsequent follow-up. This involves 5 cases with pharmacists required to interact with patients in different situations.
- **Communication skills** which examines the ability of pharmacists to communicate in terms of verbal and non-verbal expression; empathy; organisation of the interview and coherence; and clinical knowledge.

All of the cases used in the process are written and reviewed by practitioners to ensure that they remain relevant to the practice of pharmacy and reinforce the peer review ethos. The peer review process ends with a feedback session and the results from the peer review are submitted to the Quality Assurance Committee, with each candidate also receiving a performance report.

This peer review process seems to offer a relatively cost effective and robust method of assessing and ensuring competency for pharmacists in Ontario. By allowing trained peers to validate competency, it has the advantage of engaging the profession and moving away from an 'us and them' perspective of the regulatory authority.

[24] Austin Z, Croteau D, Marini A, Violato C. Continuous professional development: The Ontario experience in professional self-regulation through quality assurance and peer review. American Journal of Pharmaceutical Education 2003; 67(2): Article 56.

4.6 United States

There has been a drive in the United States in recent years to move from an approach of mandatory participation in continuing education to wider engagement in CPD across the profession and across all states. This presents a significant challenge as the scale of the profession and the different approaches in place across different states. This limits the learning from an Irish context in some respect, but the piloting of CPD across 5 states is a lesson in the need to test approaches and build buy-in for a CPD system to prove successful.

Playing a significant role in breaking down the barriers between the varying state approaches and building consistency is the Council on Credentialing in Pharmacy (CCP)[25]. The role of this organisation is to provide leadership, guidance and public information for the profession of pharmacy's credentialing programmes. The vision of CCP is that all credentialing programmes in pharmacy will meet established standards of quality and contribute to improvement in patient care and the overall public's health. Its Pharmacy Technician Credentialing Framework lists a number of components in relation to education, training, certification, and regulation of pharmacy technicians, but all are quite generic and offer limited direction in moving forward CE and CPD.

4.6.1 The nature of the system

In 1965, the state of Florida was the first to implement mandatory continuing education. Today, 49 states, with the sole exception being Hawaii, require pharmacists to participate in mandatory CE. The approach in all these states is to link CE to the process of renewing a license to practise. The license period varies from state to state, although two years is a fairly typical lifespan. One of the requirements for re-licensing is the completion of a specified number of hours of approved/accredited CE.[26]

A five-state (Indiana, Iowa, North Carolina, Washington, Wisconsin) CPD pilot program was launched in 2006 and ended in October 2007. The programme, which was organized by several state pharmacy associations, sought to develop and evaluate a process for accomplishing CPD that could be used by pharmacists in the United States. A secondary purpose of the pilot project was to gather information about the effectiveness of CPD as a learning model compared to the standard CE process[27].

Although this pilot has not led to full roll-out of CPD across the US, many of the American states are still using the traditional *Continuing Education* model of development. However, there has been a lot of discussion in recent years about the value of this model and many states are looking at new ways of modernising their professional development competence systems to deliver pharmacy services in an increasingly patient-oriented environment.[28]

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[25] Website: www.pharmacycredentialing.org

[26] "International Trends in Lifelong Learning for Pharmacists", Annelies Driesen, PharmD, Koen Verbeke, PhD, Steven Simoens, PhD, and Gert Laekeman, PhD, Am J Pharm Educ. 2007 June 15; 71(3): 52.

[27] http://www.acpe-accredit.org/ceproviders/CPD.asp

[28] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1913290/

4.6.2 Approach to standards

The mandatory continuing education approach means that there are generally broad standards in place in each state with regard to the pharmacist's **engagement in CPD**. The requirement is typically based on a number of hours of participation and the average requirement is 30 hours every 2 years. Some states require a minimum number of credits to be collected from participation in live courses (e.g. Florida). Others require a minimum number of ACPE-accredited courses (e.g. Indiana). Others specify specific topics for which points have to be collected (e.g. Arizona, every 2 years pharmacists should followed at least 3 hours on pharmacy law)[29].

The CCP has defined broad competencies and expected outcomes from pharmacists in its Scope of Contemporary Pharmacy Practice: Roles, Responsibilities, and Functions of Pharmacists and Pharmacy Technicians'. However while this framework is useful and relatively detailed in comparison with international comparators, it is unclear as to what influence it actually exerts on Practice at state level. The most practical US-wide approach to standards surrounds the nature of the CE activities that can be accredited. This approach is further detailed in section 4.6.3 below.

4.6.3 Accreditation of CPD

The Accreditation Council for Pharmacy Education (ACPE) sets accreditation standards and accredits CE providers, rather than individual CE activities. The ACPE is an independent agency whose board is derived through the American Association of Colleges of Pharmacy (ACCP), the American Pharmacists Association (PAhA), the National Association of Boards of Pharmacy and the American Council of Education. The ACPE recently revised its standards for accrediting continuing pharmacy education (CPE). These standards have been effective since January 1, 2009. The standards make clear the requirements from any CPD activity to allow it to be accredited, as summarised in Figure 4.5.

Figure 4.5: Standards Underpinning Accreditation of CPD in the US

Content of Continuing Pharmacy Education Activities 1: Goal and Mission of the CPE Program 2: Educational Needs Assessment 3: Continuing Pharmacy Education Activities 4: CPE Activity Objectives 5: Standards for Commercial Support	**Delivery of CPE Activities** 6: Faculty 7: Teaching and Learning Methods 8: Educational Materials
Assessment 9: Assessment of Learning 10: Assessment Feedback	**Evaluation** 11: Evaluation of CPE Activities 12: Achievement and Impact of CPE Mission and Goals

[29] "Global Pharmacy Workforce and Migration Report", International Pharmaceutical Federation (FIP), 2006

The ACPE is encouraging the adoption of continuing professional development as a lifelong learning approach via inclusion of CPD in the revised standards and by disseminating information about the process.

4.6.4 The assessment process

The ACPE Standards provide guidance for assessment of learning. These state that completion of a learning assessment is required for a CPE credit: “The provider may select formal and informal techniques for assessment of learning. Formal techniques, such as tests and quizzes, are typically individualised, written and graded. The assessment should be consistent with the identified CPE activity objectives…and activity type”.

Therefore the requirements for learning assessment by providers vary according to the type of CPE activity:

- Knowledge-based CPE activity: Assessment questions structured to determine recall of facts.
- Application-based CPE activity: Case studies structures to address application of the principles learned.
- Practice-based CPE activity: Formative and summative assessments that demonstrate the pharmacists and technicians achieved the stated objectives.

Learner assessment feedback, appropriate to the type of activity, must be provided to participants in “an appropriate, timely and constructive manner”.

4.7 Great Britain

The pharmacy sector in Great Britain is currently experiencing a significant change in terms of how pharmacy is regulated. The Royal Pharmaceutical Society of Great Britain has been the professional body and the regulatory authority for pharmacists and pharmacy technicians in England, Scotland and Wales. In response to the Government White Paper, ‘Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century’[30], the professional and regulatory functions will now been split between two separate and independent bodies.

[30] Department of Health, The White Paper Trust, Assurance and Safety: The Regulation of Health Professionals, 2007, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_065947.pdf

During 2010, the General Pharmaceutical Council (GPhC) will become the regulator of the pharmaceutical sector in England, Scotland and Wales, with the Professional Leadership Body (PLB) assuming the role of the professional body for pharmacists in Great Britain (excluding Northern Ireland). This role is to be taken on by the RPSGB, with the English, Welsh and Scottish Pharmacy Boards feeding into this organisation via an assembly which will maintain overall strategic direction on Great Britain issues. These Boards in turn will be linked to newly established local networks of pharmacists called Local Practice Forums which should facilitate the sharing of learning and good practice between peers. Northern Ireland has a separate body, the Pharmaceutical Society of Northern Ireland, which acts as the regulator and professional body for the pharmacy sector in Northern Ireland and the differences in approach to CPD as a result are further discussed in section 4.8.

In a time of such change there is much to learn from the bedding in of this system in Great Britain at the same time as the Irish system is being developed. The separation of professional and regulatory functions, move to a flexible and non-prescriptive CPD approach and use of interactive online tools for self-reflection and assessments are all key aspects of the model, and their potential influence on practitioner development in pharmacy is further examined in the paragraphs below.

4.7.1 The nature of the system

The introduction of statutory professional development is a key aspect of the establishment of the General Pharmaceutical Council. With the overriding interest defined in establishing the new approach as “the safety of the public and the quality of care they receive”, a CPD system that focuses on impact on practice is a key goal. As a result a highly flexible approach has been adopted, with no prescribed courses or activities to be undertaken. Instead there is a focus on self-reflection on how action has influenced practice, with a desire to recognise more informal and work-based learning. A wide variety of activities are now eligible for registration as CPD activities, including:

- Finding new knowledge and learning a new skill relevant to the job;
- Changing the way things are done or adoption of a new behaviour;
- Anything where pharmacists learn from their actions and improve their performance as a result.

Introducing such a significant change poses a series of challenges. It requires behavioural change across the sector, but there has been concern that the time allowed to phase in this non-prescriptive and flexible approach has been insufficient to achieve the required level of buy-in. The lack of a clear and logical relationship between particular CPD activities and improved patient outcomes will also make the overall impact of the change difficult to ascertain. This relationship will be down to the perceptions and insight of the individual pharmacist.

On the other hand there are benefits to this empowerment of the professional, and feedback suggests that the self-reflection component is increasing the focus on the pharmacist on how CPD learning improves the way in which they perform their duties on a day-to-day basis in a manner that avoids being overly onerous. It also must be acknowledged that an increasing number of tools and resources are being released by the Professional Leadership Body, including the launch of a new information and advice service (IAS) and CPD review service and a CPD toolkit for Local Practice Fora.

Funding of the system will be via a combination of Government support and pharmacist contribution via an annual membership fee. This fee, introduced from 2011, has been set at £192. In exchange it will offer access to the services of the Professional Leadership Body in support, development, networking, leadership and recognition. The annual fee will be tax advantageous, with the RSPGB estimating that the net fee burden can be reduced to £9 per month depending on income.

4.7.2 Approach to standards

The system in GB is not prescriptive in terms of a competency framework for CPD or in the standards that must underpin CPD activities. Instead it focuses upon standards for engagement in CPD by the professional. This is intended to ensure that there is a rigorous and well-developed approach to the recording process, with every CPD entry documented in a portfolio (online, through the website of the RPSGB, or on paper) in line with the elements of the CPD cycle, including reflection, planning, action, and evaluation. The CPD standards introduced for pharmacists on 1st March, 2009 require pharmacists to:

- Keep a legible record of CPD;
- Make a minimum nine entries per year,
- Reflect and record how CPD tasks have helped improve the quality of practice.

There are no defined standards to frame the type of CPD activities that participants must report, as long as the activities contribute to the pharmacist's professional development. Examples include:[31]

- Learning knowledge and skills at conferences and courses;
- Practice-based learning, including feedback from patients and audits;
- Analysis and review of critical incidents;
- Self-directed learning, including reading, writing and undertaking research;
- Learning with others, including peer review;
- Interactions with other healthcare professionals;
- Giving lectures and writing publications and the design and delivery of training courses.

[31] The Royal Pharmaceutical Society of Great Britain, Professional Standards and Guidance for Continuing Professional Development, 2009, http://www.rpsgb.org/pdfs/coepsgcpd.pdf

4.7.3 Accreditation of CPD

As GB moves increasingly towards a more flexible and reflection-based system, the emphasis on accreditation might be expected to diminish. However, the College of Pharmacy Practice has established itself as the major body within the pharmacy profession for accrediting and providing continuing professional development events and materials. It does this principally through the Centre for Pharmacy Postgraduate Education (CPPE), which offers learning to practising pharmacists and pharmacy technicians providing NHS services in all sectors of practice including community, hospital, prison and primary care pharmacy.

The college has recently revised its accreditation criteria to ensure that it is operating in line with current professional requirements, in particular in light of the recent and ongoing shift in emphasis from continuing education to continuing professional development. Since 2005, the College of Pharmacy Practice has been accrediting everything against the RPSGB's CPD Competency framework, in line with the standards for engaging in CPD defined above.

There is also a strong emphasis on developing a CPD system that can support development of advanced level and specialist competencies for pharmacists. The Professional Leadership Body intends to lead this work and create standards and frameworks around advanced and specialist practice, including accreditation and awarding titles or levels of membership.

4.7.4 The assessment process

Since 2005, pharmacists and pharmacy technicians have been required to make an annual declaration when registering stating their compliance with the Code of Ethics requirement to maintain a CPD record. However a statutory assessment process will begin in April 2010 with the establishment of the GPhC. The RPSGB is currently trying to encourage members to make CPD entries before the statutory CPD assessment process is introduced in April 2010, and is developing transitional arrangements, to enable CPD records created before the statutory requirements are in place to form part of the assessment process. It will be the responsibility of the GPhC to set out a framework and criteria for the statutory process.

The RSPGB CPD package, 'Plan and Record', has been established as the main recording and assessment tool and will continue to underpin CPD when it becomes a statutory requirement. Under the system, pharmacists are instructed to aim for 12 CPD entries a year. In order to make the system work, a rigorous framework guides them in the recording and self-assessment process. Every CPD entry has to be documented in a portfolio (online, through the website of the RPSGB, or on paper) according to the elements of the CPD cycle, including reflection, planning, action, and evaluation. In the reflection part, learning objectives have to be stated, as well as the methods used to identify those objectives and related areas of competence. In the planning field, pharmacists note, among other things, the date by when the learning objectives have to be met as well as the planned activities. The action paragraph reports on the completed activities with the estimated time taken, whereas in the evaluation part, details are provided on the extent to which the learning objectives have been met, examples of application of the learning outcomes, feedback from other persons, etc. There have been some teething problems with the new online assessment tool, with the RPSGB responding to criticism in July 2009 and amending the tool to make it simpler and more streamlined.

The RPSGB can request CPD records for review at any point in time and in the past this has typically taken place every 3 to 5 years. In cases where poor CPD records are identified, detailed feedback will be provided to the pharmacist on how to improve them, and if that is still insufficient, support may be offered from a RPSGB CPD facilitator.

4.8 Northern Ireland

The Pharmaceutical Society for Northern Ireland is the professional body and regulator for pharmacists in Northern Ireland. The Society issued a response to the UK Government White Paper referenced above in its paper, 'Future of Pharmacy, registration, regulation and representation in Northern Ireland'[32]. The Society recommended that, given the return to devolution in 2007 and all aspects of health being devolved, registration, regulation and representation of pharmacy in Northern Ireland should be done by a bespoke model that meets the needs of patients and pharmacists in Northern Ireland.

The PSNI suggested using the model used by the Law Society for Northern Ireland, a model that is very much in-line with the preferred model suggested in the White Paper. Under the proposed model, all aspects of the adjudication process would have to be independent of the PSNI through a new independent statutory committee. The PSNI would be responsible for registration of pharmacists and technicians, their premises and examinations. It would also support Continuing Professional Development and re-validation of competence, offering professional guidance, standards and professional leadership.

[32] The Pharmaceutical Society of Northern Ireland, Future of Pharmacy Registration, Regulation and Representation in Northern Ireland, 2008, http://www.psni.org.uk/documents/324/Microsoft+Word+-+future+PSNI+final+doc+website+version.pdf

4.8.1 The nature of the system

CPD has been a professional requirement for all pharmacists in Northern Ireland since 2005, with compliance seen as a key ethical and professional obligation. The Society is currently seeking the legislation from the Department for Health, Social Services and Public Safety (DHSSPS) to make continued registration a statutory requirement.

The system is based on a four stage cyclical process involving reflection (identification of learning needs); planning (what activities will be undertaken to meet the learning needs and when?); action (documenting what was learned) and evaluation (deciding if learning needs were met and how this has been used in professional practice). As with the GB system, significant emphasis has been placed on use of an online recording and reflection tool, accessible by members from the PSNI website.

CPD in Northern Ireland is coordinated by the Northern Ireland Centre for Pharmacy Learning and Development (NICPLD). This is funded by DHSSPSNI and provides programmes of activities accessible to all pharmacists registered to practise in Northern Ireland (who pay an annual registration fee of £372 to the RSPNI, which has a dual remit as a regulatory and professional body). In addition, NICPLD offers two funding streams are available to enable pharmacists to engage in CPD activities not directly provided by NICPLD. A CPD Grant scheme provides financial support to enable pharmacists to participate in courses, workshops or conferences related to their professional development. Bursaries enable hospital pharmacists to undertake training in clinical pharmacy at the School of Pharmacy, Queen's University.

4.8.2 Approach to standards

The Society has developed a series of competency-based standards and guidelines for a number of aspects of pharmacy practice including: patient consent; patient confidentiality; sale and supply of medicines; advertising medicines and professional services; internet pharmacy services; pharmacist prescribers; Responsible Pharmacist Regulations; and Community Pharmacy Premises Standards.

Standards are also in place with regards to how pharmacists engage in CPD in Northern Ireland. Pharmacists are required to:

- Consider the knowledge and skills needed to fulfil their role and assume their responsibilities
- Identify any areas in which they need to update or develop
- Take appropriate action to address these areas
- Assess whether their actions suitably met your needs and how you can implement these into your working practices

Pharmacists are expected to be aware of any changes that might affect their role and responsibilities and to ensure that they are up-to-date in order to carry these out competently.

While there are no strict standards underpinning the nature of CPD, there are Society guidelines on the activities recognised as making a valid contribution to CPD:

- Workshops,
- Distance learning,
- Study groups,
- Private reading,
- Teaching,
- Making presentations,
- Speaking to peers,
- Conferences,
- University courses,
- Mentoring,
- Work-shadowing
- Research.

4.8.3 Accreditation of CPD

There is a wide variety of course providers. The PSNI formally accredits Northern Ireland MPharm providers (undergraduate) and the QUB Independent Prescribing (IP) course. The IP course can be taken by post-registration pharmacists and therefore there are entries in CPD portfolios relating to this type of formal course. For other types of learning, the (NICPLD) is the main provider for live and distance learning opportunities for pharmacists registered in Northern Ireland, and many choose these to further their CPD. Pharmacists also use a range of other live and open-learning sources of continuing education to assist with their CPD. The Health & Social Care Board (HSCB) also organises training days and workshops.

4.8.4 The assessment process

Pharmacists are required on annual registration to complete a self-declaration form stating that they have undertaken 30 hours of CPD (five hours of this are allowed for documentation of CPD cycles). There is formal assessment of each cycle against the evaluation criteria used by the PSNI. Pharmacists may be randomly selected to submit their evidence, and compliance with CPD is also considered on a number of other occasions, if for example a complaint is made against them.

Northern Ireland deploys a portfolio based system of recording CPD, in line with many other models. Pharmacists' CPD portfolios sets out how to record their CPD and blank CPD record sheets are provided. There is also an online means to record CPD through the website of the NICPLD. Pharmacists are required to produce this portfolio on an annual basis for assessment, with the onus on the pharmacists to demonstrate the required 30 hours of learning in line with their self-declaration form. When their CPD portfolios are assessed by PSNI, pharmacists receive a formal report with feedback and one of four possible graded results (Options 1-4). Where portfolios are awarded Options 1 and 2 no further action is required; Option 3 portfolios are deemed to have met the required standard, but the pharmacist will be asked to submit a portfolio the following year; pharmacists whose portfolio has been awarded an Option 4 will receive notification that they are to submit further CPD cycles as part of the Reassessment Process.

4.9 The Netherlands

The approach in the Netherlands remains centred around continuing education. The 'BIG' (Beroepen Individuele Gezondheidszorg) law was introduced in 1997, which set clear criteria for registration and re-registration of eight professions that are involved in the delivery of direct patient care, including the community pharmacist. Criteria for registration in the BIG-register are related to successful completion of graduate education, whereas criteria for re-registration relates work experience and participation in Continuing Education. As a result of this law there is a mandatory requirement for all pharmacists to engage in CE, with registration linked to the ability to obtain health insurance. This is a predominantly input based system with participation in learning and attendance at courses and seminars awarded with credit points. However there is an increasing push towards linking this activity to testing and assessment to ensure greater focus on learning outcomes. The lack of a competency framework post initial registration is also a cause for concern, and it is expected that a more robust system of practitioner development will emerge in the coming years.

4.9.1 Nature of the system

Continuing Education has been mandatory in the Netherlands since 1995. A system of registration and re-registration was introduced by KNMP, whereby health insurers in Holland agree only to enter into contracts with KNMP-registered pharmacists. As a result, pharmacists who do not meet their CE commitments may run the risk of losing their contract with the health insurers.

A number of different organisations are involved in the management and implementation of the CE system for pharmacists in the Netherlands. The Royal Dutch Pharmaceutical Society (KNMP) is the professional body for Dutch pharmacists and provides funding support for a range of CE activities. A central body sets the standards and criteria for Continuing Education activities and finally, an accreditation commission evaluates accreditation applications from CE providers. Within hospital pharmacy, the NVZA (Dutch Association of Hospital Pharmacists) has placed significant emphasis on the development of regional knowledge centres to support sharing of learning and has invested significantly to achieve this.

4.9.2 Approach to Standards

As noted above, the BIG law sets down a clear expectation in terms of engagement in CE by the pharmacist, although this has yet to be formalised within a specified series of standards. However the debate surrounding a lifelong learning system for pharmacists in the Netherlands continues and further reforms are expected. A critical report of the Dutch Institute for Effective Use of Medication recommended that:[33]

- pharmacists should do 60 hours of CE per year instead of 40
- more courses on pharmacology and pharmacotherapy should be offered

[33] Annelies Driessen, Koen Verbeke, Steven Simeons, Gert Laekeman, International Trends in Lifelong Learning for Pharmacists in Am J Pharm Educ. 2007 June 15 (3)/: 52

- control should be exercised by means of examinations instead of attendance registration
- CE should be competency based in accordance with graduate education
- the influence of the pharmaceutical industry on CE should be controlled, and visitation reports of the accreditation commission should be made public.

The lack of competency standards to underpin continuing education activity is therefore a cause for concern. Action can be expected to address this issue over the next few years, with a framework established to underpin a more robust and outcomes-focused approach to continuing education.

4.9.3 Accreditation of CPD

The KNMP provides accreditation for courses, conferences etc and mandates the credit points that are gained by participation in these. For example, ACPE congress sessions are allocated 3 credit points for the registration of community pharmacists. An accreditation commission evaluates accreditation applications from CE providers and may visit accredited courses unannounced. The NVZA (Dutch Association of Hospital Pharmacists) also plays a role in accreditation and can allocate Continuing Education Credits to certain activities.

4.9.4 The assessment process

As noted above there is a continuing education credit based assessment system in the Netherlands, overseen by the KNMP and linked to the annual re-registration process. Pharmacists must maintain a record of all CE activities and the credits awarded, and demonstrate participation in at least 40 hours of CE per annum.

4.10 Finland

The development of community pharmacy services in Finland has been characterized by strong collaboration among the professional associations, university departments of social pharmacy, continuing education centres, and practicing pharmacists. Perhaps the most unique aspect of the Finnish system has been the establishment of formal learning and development centres to deliver prescribed programmes of CPD across the country. This helps ensure a high degree of consistency in terms of CPD engagement across the profession. However there would appear to be a lack of flexibility in the system which constrains the extent to which it can respond to the needs of pharmacists in different settings.

4.10.1 Nature of the system

In Finland, CPD for pharmacists is not mandatory. However, the National Agency for Medicine regulate community pharmacy licenses with a limited number available across the country. If there is competition for a license, the license will be granted to the applicant who can prove that they have participated in a continuing professional development programme of some description.

Continuing professional development (CPD) in Finland is planned and coordinated at both a local and national level to address the community pharmacy strategy and key healthcare priorities. The intra-disciplinary approach across healthcare is an important focus with the National Agency for Medicines controlling regulation of the community pharmacy sector.

In-house training, as well as long-term and short-term continuing education, has a long tradition in Finnish community pharmacies, dating back to the early 1980s. Updating professional knowledge has become a norm among Finnish community pharmacists, despite not being mandated by law before 2006. The strong commitment to practitioner development in this regard is demonstrated by the fact that 76% of pharmacists with a Bachelor's degree and 85% of those with a Master's degree actively participated in CPD activities in 2001[34].

Government funding supports delivery CPD activities in Finland via for a series of non-profit centres which are further discussed below. There is also an expectation that the individual pharmacist contributes a fee for participation in any CE or CPD activity. Finland also has an interesting industry-based funding model which pools investment to avoid bias in delivery and this is also further detailed in the following sections.

4.10.2 Approach to Standards

In Finland, a strong and academically-focused approach to development and delivery of CPD is in place. CPD activities are primarily organized by several non-profit associations that work closely with the pharmacy schools. The oldest of these is the Pharmaceutical Learning Centre, which was founded in 1980. The Palmenia Centre for Continuing Education, an independent institute of the University of Helsinki and the University of Kuopio's Centre for Training and Development offer both short and extended courses in a range of pharmacy-related topics.

The development of these Institutes, linked closely to the schools delivering the undergraduate pharmacy degree in Finland, suggests that this type of delivery model can offer a high quality system of CPD that builds on a practitioner development pathway that extends from pre-registration to ongoing practice and advancement throughout a career.

The status afforded each of the institutes or learning centres means that the approach to standards is derived from each of these CE providers. For example, the Pharmaceutical Learning Centre and organisations linked to the universities provide most of the CE programmes for pharmacists and they follow their own standards. This provides a strong academic basis for the learning and strong collaboration between schools and across the profession means a high level of confidence in the quality of the education being delivered.

[34] "Providing Patient Care in Community Pharmacies: Practice and Research in Finland", J Simon Bell, BPharm(Hons) PhD, Minna Väänänen, MSc(Pharm), Harri Ovaskainen, MSc(Pharm), Ulla Närhi, MSc(Pharm) PhD, Marja S Airaksinen, MSc(Pharm) PhD Published Online, 15 May 2007, DOI 10.1345/aph.1H638. The Annals of Pharmacotherapy: Vol. 41, No. 6, pp. 1039-1046

4.10.3 Accreditation of CPD

CPD activities are accredited by the organisations established as provider institutions discussed above, such as the Palmenia Centre for Continuing Education and the University of Kuopio's Centre for Training and Development. They offer both short and extended courses in a range of pharmacy-related topics. Continuing education is also organized and accredited by the AFP, the Finnish Pharmacists' Association, and the Finnish Pharmacists' Society. Overall, there is quite a programme-based approach to professional development in Finland, with, for example, long-term professional development programmes in place for community pharmacists. These programmes aim to upgrade practicing pharmacists in management, business and professional skills. This moves the system away from a credits based system with the expectation that the pharmacists engages in certain programmes of this kind to maintain competency.

4.10.4 The assessment process

As Finland does not have a mandatory system for CPD or CE, there is no formal assessment process linked to registration. The system is based around voluntary engagement in specified long-term continuing education programmes rather than a credits-based approach. However the strong levels of take-up suggest that it is viewed a core part of a pharmacist's responsibilities.

4.11 Implications for the Irish CPD system for pharmacists

The review of international CPD models for pharmacy highlighted significant diversity in approach. Many systems evolved over significant periods of time and built upon existing organisations, infrastructure and arrangements to become established in their current form. The need to tailor the CPD system around the particular characteristics of the profession and the environment in which it operates within each geography was clear. There was found to be no 'off the shelf' solution that we found to map exactly to the needs for a system in Ireland. Indeed the research emphasised the need to design a unique system for Ireland to reflect its particular circumstances. There remains significant learning to inform the development of an Irish system however, with the implications including:

- The funding of CPD systems varies across geographies but generally involves some public expenditure in recognition of its contribution to national healthcare objectives, some contribution from the regulator in line with its need to ensure the competency of the Register and a degree of self-sufficiency by the profession itself in recognition of the acknowledgement
- Mandatory systems are increasingly adopted as the most appropriate approach for CPD in pharmacy and we would recommend this course of action for the Irish system. Clear governance and management structures will however be essential to ensure clarity and consistency for the professional.
- Keeping the system simple and avoiding onerous requirements will be important in development of the Irish system. It will be important to adopt an incremental approach to implementation avoiding an overly ambitious switchover to extensive new mandatory requirements which risks disillusionment and lack of buy-in from the profession.

- The definition of specific standards to frame CPD programmes is varied across geographies. A range of different systems are in place, focusing on three different aspects. In Portugal there is an emphasis on standards for the CPD activities being delivered and how these link to wider learning objectives. The US has adopted a similar approach for continuing pharmacy education. Great Britain provides an example of standards that place responsibility on the professional to engage appropriately in CPD. New Zealand and British Columbia have reinforced the need for CPD to influence practice by defining prescribed competency standards reflecting the attributes required by a pharmacist to operate effectively. The Irish system should recognise the importance of a competency-based standards system which also makes clear obligations for the pharmacist in engaging in CPD and for providers in offering CPD activities.
- Accreditation systems are usually designed and operated by the regulatory bodies (USA, Great Britain, Australia) although the Netherlands has established a separate accreditation body to assess applications and randomly check CPD activities. While in most cases accreditation is still based on verifying the quality of CPD activities, Finland has adopted the approach of accrediting non-profit organisations to deliver CPD programmes. While accreditation in CPD remains important, there is a growing emphasis on recognition of informal CPD activities (e.g. peer networks, bitesize training courses, journal reflection) that cannot be easily accredited. The approach tends to involve identifying how these types of activities contribute to meeting overall CPD requirements. In Portugal, for example, CPD credits are awarded for attending conferences and scientific meetings and for teaching activities. New Zealand allows allocation of credits based on the outcome on practice. Accreditation of formal CPD activities in the Irish system is important to assure quality, but this system must also allow for recognition of participation in informal activities that cannot be accredited.
- Assessment systems vary but predominantly adopt a self-assessment approach, requiring the pharmacist to keep a record or portfolio of CPD undertaken which has to be submitted to the regulatory body on request (GB, Ontario, British Columbia). Australia adopts a slightly less prescriptive approach, defining an overall framework for recording and assessing CPD but not requiring this in a set format. Increasingly there is a focus on assessing the impact of CPD on practice (New Zealand, GB) with reflective online tools a key emerging trend to facilitate this – however the complexity of the system has created issues of buy-in. Most portfolio or record based systems employ credits/points/ hours based system of measuring CPD, requiring demonstration of how the pharmacist has met a minimum level of engagement (the Netherlands, Northern Ireland, BC, US). The self-assessment processes are accompanied by periodic mandatory assessment exercises in Canada, based on an examination of clinical knowledge in British Columbia, with a peer-led practice review exercise in place in Ontario. While costs inevitably constrain the extent of this sample, it must be sufficient to ensure that the expectation of external assessment motivates the professional to engage in CPD and maintain adequate records. Taking on board this learning, it is important that the Irish assessment system requires the pharmacist to engage in a balance of different CPD activities, without being overly prescriptive about a set number of credits or points that have to be obtained.

5 Approach to CPD in other professions

In this chapter of the report, we look at some of the high-level trends and patterns in CPD models by profession, identifying examples from different geographies on how CPD is delivered. The next four sub-sections looks at each of the healthcare professions; medicine, nursing, radiography and physiotherapy. We then also look at non-healthcare professions in the form of teaching, aviation and accountancy. The chapter concludes with analysis of the implications of the research for the Irish system of CPD for pharmacists.

5.1 Physiotherapy

Points to consider in development of the Irish model for mandatory CPD:

- National CPD systems and approaches are underpinned by a globally recognised framework
- There is a strong, international trend towards mandatory CPD
- There are several examples of web-based recording systems, to facilitate both maintenance of records by the professional and the assessment process.

5.1.1 Nature of the system

Physiotherapy in many countries is making the move toward mandatory rather than voluntary CPD. CPD is mandatory for physiotherapists in Ireland, the UK, the Netherlands, Australia, New Zealand, the USA (31 of 53 states).[35] CPD is voluntary in Canada, however the Canadian Physiotherapy Association identifies it as a 'priority and expectation' of its membership.[36]

[35] An overview of Continuing Professional Development in physiotherapy, H.P. Frencha, J. Dowdsb and on behalf of the Dublin Academic Teaching Hospitals Physiotherapy CPD Project Group. Physiotherapy Volume 94, Issue 3, September 2008, Pages 190-197

[36] Canadian Physiotherapy Association website: www.physiotherapy.ca Professional Development Section

The UK Health Professional Council mandates that physiotherapists (along with other professional groups) must carry out CPD in line with the UK Chartered Society of Physiotherapists (CSP) recommendations to retain registration. Irish physiotherapists participate in a similar system, where members of the Irish Society of Chartered Physiotherapists have been required since 2005 to demonstrate evidence of completion of CPD in order to renew their membership. This move was in anticipation of the set up of the Health and Social Care Professional Council, who on commencement of statutory registration of groups including physiotherapists, are expected to make this a mandatory requirement of for re-registration.

5.1.2 Approach to standards

The World Confederation for Physical Therapy (WCPT)[37], the world governing body for physical therapists and physiotherapists (chartered physiotherapists in Ireland), outlines that "Physical therapy education is a continuum of learning beginning with admission to an accredited physical therapy school and ending with retirement from active practice". It also acknowledges that lifelong learning and professional development underpin a competent professional, and that learning and development take place in a variety of ways not limited to the attendance at formal courses.

Geographical regions have developed standards based on the WCPT principle. Section 2.04 of the European Region of the WCPT European Core Standards of Physiotherapy Practice outline the standards related to CPD and Lifelong Learning[38]. Criteria are set out in relation to the assessment of needs by the therapist, CPD planning, implementation and evaluation. Member organisations have adopted these core standards to guide the development of professional education in their states[39].

[37] The World Confederation for Physical Therapy website: www.wcpt.org

[38] European Region of the World Confederation for Physical Therapy: European Core Standards of Physiotherapy Practice ADOPTED FINAL VERSION at the General Meeting 09/11 May 2002 Budapest/Hungary; REVISED at the General Meeting 22-24 May 2008 Athens, Greece

[39] Informative Paper with Recommendations on Continuous Professional Development: European Region of the World Confederation for Physical Therapy, May 2006

5.1.3 Accreditation of CPD

The Australian Physiotherapy Association has a structured system of accreditation of CPD courses – the National Course Accreditation Committee.[40] Once a course has been accredited professionals receive more points for participating in it when compared to a non-accredited course or informal activity. The ISCP have taken this a step further recently by launching their own accredited e-learning modules for their membership. Irish physiotherapists can log on to their ISCP account, complete modules, carry out assessment in the module and receive CPD points for their learning. This not only ensures that they complete accredited learning that is based on current evidence based practice, but also provides through the assessment component an element of reflection and examination of the learning. In the Netherlands, the Royal Dutch Society for Physical Therapy (KNGF)[41] accredits courses, and mandatory courses can be assigned for specific topics.

5.1.4 The assessment process

All of the countries studied required the physiotherapist to maintain and have available a record of their CPD activities. The approach to how this is facilitated varies, but there is an increasing trend towards web-based recording systems.

In the UK, practitioners are required to maintain a log in CPD folders; filling in reflective practice forms after either formal or informal CPD activities, identifying how it has addressed the learning need. Physiotherapists must produce this folder if requested for audit by the HCP and could face deregistration if it is not sufficiently maintained.[42]

The Australian Physiotherapy Association also has a web-based system of logging points for CPD. Compliance is monitored through annual random audit.

New Zealand physiotherapy registration requires a log of a minimum of 100 CPD points over a three year period for the recertification program. One hour of recorded professional development activity will earn one CPD point. These can be accumulated in the areas of work-based learning, professional activity, self directed learning and formal/educational activity.

The KNGF website provides each physiotherapist with a personal page, which shows their current portfolio based on accredited activities.

[40] Australian Physiotherapy Association website: www.physiotherapy.asn.au

[41] Royal Dutch Society for Physical Therapy (KNGF)

[42] The Chartered Society of Physiotherapy: www.csp.org.uk

Case Study: A Focus on Ensuring Competency for Physiotherapists in British Columbia

The College of Physical Therapists of British Columbia (CPTBC) is the regulatory authority for physical therapists in province, operating within the legislative framework provided by the Health Professions Act. The CPTBC sets standards for entry into the profession, registers physical therapists, sets and enforces a set of rules that registrants must follow and develops programmes to promote the highest standards of physical therapy practice.

These programmes form the core of the approach to practitioner development in BC, with an overarching aim to ensure competence and protect the public interest. A quality assurance system has been put in place by the College that consists of three layers:

- Annual self report: Registrants declare their competence through an annual self-report – The process will encourage ongoing self-reflection on their practice (2010)
- Competence Assessment: Registrants show or demonstrate competence using peer developed and agreed upon standards (2012)
- Support practice: Some registrants require further support to overcome difficulties and improve practice (2012)

The programme will:

- Support registrants continued competence by expanding their knowledge and understanding of their professional, legal and ethical obligations
- Provide a structured method of reflection and support and opportunities for improving registrants' competence;
- Assure public and government that participating professionals are held accountable to recognised standards

5.2 Medicine

Points to consider in development of the Irish model for mandatory CPD:

- The World Health Professions Alliance core competency framework has led to the internationalisation of competency standards
- The trend is towards mandatory CPD, however CPD is embedded in the culture of medicine as a professional imperative.

5.2.1 Nature of the system

Internationally there is a move from continuing medical education (or clinical update) to continuing professional development, including medical, managerial, social, and personal skills[43]. The organisation and delivery of CPD varies from country to country. It is usually driven and managed by the medical associations and other professional organisations, who act as initiators, providers and promoters of CPD.

[43] Continuing medical education and continuing professional development: international comparisons; du Boulay and Asbjørn Holm; BMJ 2000;320:432-435

The World Federation for Medical Education (WFME)[44] is the global organisation concerned with education and training of medical doctors. It defines CPD for doctors as the period of education and training of doctors commencing after completion of basic medical education and postgraduate training, thereafter extending throughout each doctor's professional working life. The WFME describes CPD as 'a professional imperative of every doctor' and 'a prerequisite for enhancing the quality of healthcare'.[45]

It is widely accepted that revalidation should be transparent and focused on professional development and identifying the *few* doctors who may pose a risk. Different balances of incentives and penalties are applied in different countries, the most severe penalty being revoking of the physician's license to practise. A less severe penalty is loss of certification, as in the United States, where certification is not a legal requirement to practise medicine. Not all the 24 medical specialty boards require regular recertification, but recertification may be required, for example, by medical societies and associations, health maintenance organisations, insurers, and partners in medical practices.

There seems to be consensus that self-regulation is more willingly accepted than government regulation and reduces incentives for opportunistic behaviour and non-compliance. A study commissioned for the Chief Medical Officer in England confirms that self-regulation is commonly used in Europe.[46] In some geographies, forms of co-regulation between professional and statutory bodies are being explored. This is seen as enabling greater transparency and accountability. In others there have been moves to separate the bodies undertaking licensing from those hearing complaints

In New Zealand, participation in a recognised programme has become mandatory to maintain vocational (specialist) registration. Doctors who do not satisfactorily complete recertification or competence programmes may result in the doctor's registration or practising certificate being subject to conditions or a doctor's vocational registration being suspended, in which case doctors are required to work under supervision.

In the next few years, the General Medical Council (GMC) in the UK will be changing the way doctors in the UK are regulated to practise medicine. As of 16th of November 2009, a new license to practice replaced the previous registration system to give doctors the legal authority to practice medicine. A new revalidation system is being introduced alongside the new licensing system. Revalidation is the process by which doctors will, in the future, demonstrate to the GMC on a regular basis that they remain up to date and fit to practice.

The GMC has designed a framework for appraisal and assessment for revalidation, which includes 12 different attributes and sets standards under each of those attributes, as well as suggesting possible sources of evidence for each of those standards. CPD activities provide an important source of evidence for proving competence against each of the attributes outlined.

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[44] World Federation for Medical Education website: www2.sund.ku.dk/wfme

[45] World Federation for Medical Education, Continuing Professional Development (CPD) of Medical Doctors, 2003

[46] Donaldson L,, Good doctors, safe patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients. Department of Health, 2006

Research by Merkur, Mladovsky, Mossialos and McKee in 2008 examined the revalidation of the Medical Profession in selected WHO regions[47]. This confirmed that all of the key geographies that form the subject of this study focused on some form of system of CPD or CME. It also revealed some interesting characteristics with regard to some of these countries as summarised in Figure 5.1.

Figure 5.1 Revalidation of the Medical Profession in selected WHO Regions

Country	Timeframe	Types of Revalidation		Mandatory	Penalty or Reward	Regulator
		CME / CPD	Peer Review			
Ireland	5	Yes	Yes	Yes	TBC	Medical Council
Finland	1	Yes	Yes	No	No	National Evaluation Council for Continuing Medical Education
Netherlands	5	Yes	Yes	Yes (specialists)	Removed from medical registry	Central College of Specialists
Portugal	N/A	Yes	No	No	No	Portuguese Medical Association
UK	5	Yes	Yes (360° feedback)	Yes	Failure results in practice supervision	DoH
Canada	5	Yes		Yes	Maintenance of Certification and Fellowship	The Royal College of Physicians and Surgeons of Canada

5.2.2 Approach to standards

The World Health Professions Alliance[48] has set out a core competency framework for international health consultants. Under this framework, competencies are grouped under seven domains and clusters of behaviour, skill and knowledge associated with high performance are provided for each of the core competencies identified in the framework. The seven domains are:

- Client Context
- Accountability
- Ethical practice
- Legal practice

[47]Merkur, S., Mladovsky, P., Mossialos, E., McKee, M., Policy Brief: Do lifelong learning and revalidation ensure that physicians are fit to practise?, World Health Organisation Ministerial Conference on Health Systems 25-27 June 2008

[48] World Health Professions Alliance website: http://www.whpa.org/

- Service provision
- Communication
- Continuing Competence

CPD does not always relate directly to current practice, but also extends to the capacity of doctors to make wiser judgements in situations of uncertainty that they are likely to encounter in their daily practice.

A key component of the WFME strategy is to develop international standards and guidelines for medical education, including Continuing Professional Development, that are supportive of the institutions concerned, their educational programmes, the medical profession, the doctors. The international standards will provide a framework for delivery of CPD.

5.2.3 Accreditation of CPD

Formal CPD activities are usually delivered by institutions such as medical schools, universities, postgraduate institutes, professional organisations, local or national health authorities. In some countries, there are specialised CPD institutes that deliver continuing professional development for doctors as well as other professionals. The recent growth in the private provision of CPD activities shows that the market for education as a commodity is growing. Information Technology and distance learning are increasingly influencing the market for CPD.

An interesting example of accreditation that is of relevance to the move in Ireland to develop a more inter-disciplinary focus to delivery of healthcare lies in the cross-profession approach in Australia. The Australian Government has introduced a national registration and accreditation scheme for nine different health professions: physiotherapy; optometry; nursing and midwifery; chiropractic care; pharmacy; dental care; medicine; psychology and osteopathy. A single national agency has been established to manage registration and accreditation of medical practitioners. The national registration and accreditation system will consist of a Ministerial Council, an independent Australian Health Workforce Advisory Council, a national agency with an agency management committee, national profession-specific boards, committees of the boards and a national office to support the operation of the scheme. The Australian Health Practitioner Regulatory Agency has set out a clear plan for introduction of the new system, with a scheduled launch date of the 1st of July 2010

The Australian system has also recently gone through a period of reform. The Council of Australian Governments (COAG) introduced a new system to create a single national registration and accreditation for health professionals under the direction of a newly formed Ministerial Council, comprising the Commonwealth health minister, and the ministers with responsibility for health in each of the states. The Ministerial Council will be responsible for providing policy and legislative direction, funding where appropriate, appointing members of the board and organising a system review. It will also:

- Approve profession-specific registration, practice, competency and accreditation standards and continuing professional development (CPD) requirements provided by the boards

- Request boards to review approved profession-specific registration, practice, competency and accreditation standards and CPD requirements

5.2.4 The assessment process

An international review of CPD found common features in the assessment process of the countries studied:

- CPD is typically measured using an hours related credit system, in which one hour of educational activity results in one credit;
- Educational activities tend to be divided into three categories: (a) "live" or external activities (courses, seminars, meetings, conferences, audio and video presentations), (b) internal activities (practice based activities, case conferences, grand rounds, journal clubs, teaching, consultation with peers and colleagues), and (c) "enduring" materials (print, CD Rom, or web based materials, possibly based on a curriculum, with testing or assessment);
- Where there is mandatory recertification or revalidation, showing an ongoing commitment to continuing professional development is a major component of the process.[49]

A study of the models used in Canada, New Zealand and the United Kingdom divided models for assessing continuing competence into two broad categories: the learning model and the assessment model.[50] The learning model usually rewards attendance at formal continuing medical education activities, self-assessment of learning needs, patient feedback, academic activities and audits. This model seeks to improve doctors' performance but does not identify those who are not performing to standard. The assessment model emphasises performance as well as competence and uses assessment tools to assess the performance of practising physicians, e.g. interviews, case-based oral examinations, record reviews, peer ratings and patient satisfaction questionnaires. The study identified four different types of assessment: responsive assessment; periodic assessment; screening assessment for all; and screening of high risk groups.

Medical professional bodies or licensing bodies have developed various mechanisms of control, often legally applied, specifying the required number of CPD activities in which doctors must participate. Some countries have introduced systems of re-certification that require professionals to prove that they have participated in a minimum amount of training or they may have to pass some type of exam or assessment to be re-certified. Best practice in terms of quality assurance of medical CPD should emphasise *continuous improvement*, and provide guidance for advancement as opposed to advocating fulfilment of standards as the ultimate goal.

[49] Continuing medical education and continuing professional development: international comparisons; du Boulay and Asbjørn Holm; BMJ 2000;320:432-435

[50] St George I, Kaigas T, McAvoy P., Assessing the competence of practicing physicians in New Zealand, Canada and the United Kingdom: progress and problems. Family Medicine, 2004, 36:172-177

The approach to assessment has also been underpinned by a number of tools to assist in the recording of CPD activity and reflection on and demonstration of learning outcomes. One such example is here in Ireland, where CME Diary offers a new online system that allows doctors to conveniently organise, store and access continuing medical education points. Registered medical practitioners can record medical points for internal meetings, attendance at external events and time spent reading journals or participating in other educational activities. The CME diary is a free user-friendly online diary which stores data relating to continuing professional development for doctors in Ireland. It also allows doctors to view a calendar of upcoming events. Doctors who register receive a smart card that allows them to track the number of points they have earned. It will allow them to automatically record attendance at many accredited events by scanning their cards at interactive kiosks or scanners or by texting. Despite its potential however, there remain concerns about the level of uptake of the CME diary system and whether it is actually increasing the level of focus on how learning influences practice.

Case Study: The Development of a CPD System for Surgical Specialties in Ireland

In response to the requirements of the new Medical Practitioners Act 2007, RCSI is developing a system for CPD for surgical specialties. This includes guidance on the requirements and categories for CPD as well as an appropriate electronic system which attempts to:

- Facilitate surgeons to develop a lifelong portfolio to demonstrate compliance with CPD requirements
- Allow postgraduate training bodies to monitor the compliance with CPD requirements and assist surgeons and trainees to meet requirements
- To facilitate compliance with regulatory requirements for CPD
- Facilitate the development of clinical audit as part of CPD requirements

The system will be credits-based, with a practitioner required to generate a minimum of 50 per annum. This is consistent with the Medical Council requirement for demonstration of 250 hours of CPD activity over a 5 year period, equating to 50 hours per annum, in order to remain on the Register. However a balance of different CPD activities must also be demonstrated across a 5 year cycle, including minimum requirements for external, internal and personal learning and engagement in research or teaching desirable. Examples of activities include:

- ***External*** (Maintenance of Knowledge and Skills) - Events/activities accredited by Training Bodies that meet educational standards (in person or virtually)
  - International/National meetings; College/Society meetings; Courses accredited by Training Body; Medically related advanced degrees; Online Courses
- ***Internal*** (Practice Evaluation & Development) - Activities that develop and improve the quality of clinical practice
  - Clinical clubs; Morbidity and Mortality Meetings; Clinical Risk Meetings; Case Presentations; Chart Reviews; Grand Rounds; Multi-disciplinary meetings; Peer Review Groups
- ***Personal Learning*** – Journals; Journal clubs; E-Learning
- ***Research or Teaching*** - Accredited Postgraduate Trainer; Lectures; Examiner for Postgraduate Training Body; Publishing articles; Poster presentation; National Standards Development; Question setting

A major facilitating mechanism to underpin delivery of the CPD system will be the interactive online tool Colles Portal. This brings together a series of inter-related databases which will be used by surgeons and trainees to capture and manage their CPD requirements. The system will also manage the post graduate training programmes and schemes for all surgical specialties in basic surgical training, the Irish Postgraduate Residency programme and Higher Surgical training (SpR schemes).

5.3 Nursing

Points to consider in development of the Irish model for mandatory CPD:

- Peer and manager validation of self-assessments by professionals are a common feature of nursing CPD.
- The clarity provided by the Irish Council of Nurses (ICN) in recognising and defining the important role that a variety of different stakeholders play in contributing to the continued clinical competence of practising nurses

5.3.1 Nature of the system

The ICN is the federation of national nurses' associations (NNAs), the representative bodies for nurses in more than 128 countries. Although distinct from the respective regulatory bodies in each geography, the ICN's member organisations have commited to assuring the continuing competence of nurses with the overriding purpose of the protection of public health. The ICN Model Nursing Act[51] recommends mandatory CPD linked to registration. One of the most significant achievements of the ICN has been the clear articulation of the roles that various stakeholders should play in ensuring competence in nursing. It highlights a fundamental component in any effective CPD system: definition and agreement of roles and a collaborative approach to development and delivery. The roles specified by the ICN were:

- **Public and patients** - As active partners in care, patients should provide feedback on performance and report practitioners who fail to deliver competent practice.
- **Government** is responsible for establishing the appropriate governance structure bodies, including regulatory bodies, facilitating development of appropriate legislation and regulatory systems and supports remedial action.
- The **Regulator** should establish required competencies, communicate competencies to all stakeholders, specify processes and hold individual nurses accountable through continuing competence assessment and disciplinary processes
- The **individual nurse** must understand their ethical and legal obligations, integrate competencies into practice, conduct self-assessment and participate in professional development activities
- **Employers** should incorporate professional standards into the institutional policies, assess nurses' performance, investigate complaints of poor performance and support remedial action.
- The **education community** needs to undertake research to assess the impact of competence on practice and design and deliver programmes that incorporate competences into curriculum that address current and future patient and professional needs.

[51] ICN Model Nursing Act, ICN Regulation Series, 2007 available online at http://www.icn.ch/ModelNursingAct-Eng

- **National Nurses Associations** assist in the development and dissemination of competencies, identify and facilitate the CPD needs of nurses and promote integration of competences into practice.

CPD is a mandatory requirement for nurses in most geographies, including the UK, British Columbia, New Zealand, and the Netherlands. Mandatory CPD will be implemented in Australia from July 2010 as part of a national approach to regulation of nursing. In Portugal, CPD is not compulsory by law but it is used as a basis for career development and progression – if a nurse does not engage in CPD, s/he will not be able to advance in their career[52]. In Ireland, it is not compulsory however the National Council for the Professional Development of Nursing and Midwifery is working to improve access to and take-up of CPD.[53] An Bord Altranais establishes the required standards and competencies for practice, but CPD is not currently formally used to ensure these standards are met (although a new system linking CPD to competency is now in development).

5.3.2 Approach to standards

In Australia, the Nursing and Midwifery Board developed professional standards in consultation with the profession, for each type of nurse. The general association of nurses in the Netherlands (the AVVV)[54] developed the system for quality registration and sets the standards for CPD.

In Ireland, the establishment of the Office of the Nursing Services Director has signalled a more 'hands-on' approach to standards for the development of the profession, particularly as it evolves and assumes new responsibilities. Guidelines have been issued to build competency across the profession, with the most significant example to date around new prescribing responsibilities for nurses. A review of post-registration education has also been completed and this will provide the foundation for preparation of a comprehensive strategic framework for future development, delivery and evaluation.

5.3.3 Accreditation of CPD

The research indicates a varied approach to accreditation however in general the accreditation frameworks support flexible and work-based education. This supports the strong emphasis on peer support and review. In England for example, there is not a system in place for internal or external accreditation of CPD activities[55]. In Portugal, there is a national accreditation agency which accredits programmes and courses, but also allows a flexible approach to in practice CPD activities. The development of a CPD system for nursing in Ireland will also have a balance of learning over structure, with validation by peers and managers of development valued as highly as formal accredited courses.

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[52] Report of Continuing Professional Development in Nursing: European Federation of Nurses Associations, 2004

[53] Report of the Continuing Professional Development of Staff Nurses and Staff Midwives: NCNM, May 2004

[54] Report of Continuing Professional Development in Nursing: European Federation of Nurses Associations, 2004

[55] Nursing and Midwifery Council website: www.nmc-uk.org

5.3.4 The assessment process

Peer review is common theme of the assessment process in nursing CPD and is expected to become a key component of the CPD system being developed for nursing in Ireland. The deployment of peers to confirm competency and validate development provides a cost effective mechanism of monitoring competency. It also has the advantage of placing the assessment in the context of the work-place, identifying competence in relation to day-to-day practice. If the CPD system in Ireland adopts this approach, it will be following that of a number of other geographies as further discussed below.

It is mandatory for every registered nurse to participate in the College of Nurses of Ontario's QA programme. Each year, the college selects two practice standards and / or guidelines as the focus of the year's programme. The programme includes:

- Self-assessment
- Practice assessment
- Peer Assessment.

In New Zealand, the Nursing Council of New Zealand[56] requires that all nurses will keep evidence of their continuing competence. Up to 5% of individual practitioners will be randomly selected for the recertification programme (audit) each year. The following three types of evidence must be supplied to satisfy audit requirements:

- Evidence of practice hours (a minimum of 450 hours in the last three years) verified by employer
- Evidence of professional development hours (a minimum of 60 hours in the last three years) verified by employer or nurse educator
- Evidence of assessment of competence.

In England, evidence must be provided every three years for re-registration. A sample audit of CPD records is carried out each year. In Australia, nurses will maintain an electronic or hard copy record of CPD activities. Twenty hours must be completed annually.[57] In the Netherlands, the AVVV provides a digital portfolio, which provides content and guidance as well as a mechanism to record activities.

Case Study: Mandatory CPD Requirements for Nurses in the UK

In the UK, nurses, midwives and specialist community public health nurses must register and maintain their registration to continue to operate as practicing nurses. The post-registration education and practice (PREP) programme sets out the standards required to maintain registration with the Nursing and Midwifery Council (NMC). Nurses have to undertake and record their CPD (a minimum of 5 days/35 hours over the 3 year period).

There are two separate PREP standards:

- The PREP Continuing Professional Development standards: Nurses and midwives must undertake and record CPD over the 3 years to the renewal of their registration. Nurses and midwives must declare on their NOP form that they have met the CPD requirements when they renew their registration.

[56] Nursing Council of New Zealand website: www.nursingcouncil.org.nz

[57] Australian Nursing and Midwifery Council website: www.anmc.org.au

- The PREP (practice) standards: Nurses and midwives must work a minimum of 450 hours as a nurse or midwife or must have successfully undertaken a return to practice course within the relevant 3 years.

In addition to meeting the requirements of the Post-Registration Education and Practice (PREP) standard to achieve registration, each practising UK midwife must have a 'named supervisor of midwives'. The named supervisor of midwives provides a mechanism for support and guidance and each midwife must attend at least one review of their practice and identification of training needs with their named supervisor annually.

5.4 Radiography

Points to consider in development of the Irish model for mandatory CPD:

- CPD is required to maintain registration as a radiographer
- The research suggests that CPD is a vehicle for development of the profession as radiographers broaden their skillet set through CPD, in addition to refreshing existing skills.

5.4.1 Nature of the system

Continuing Professional Development is mandatory for radiographers in many of the countries studied, including Australia, the UK, Ireland the Netherlands, Finland, and New Zealand[58]. It is not compulsory in Portugal. CPD is required to maintain registration with the regulatory body. Mandatory CPD is a relatively new and immature model in most of the countries. However emphasis has been placed on a model that facilitates practitioner development, going beyond assurance of general competency to facilitated development of advanced levels of competency and specialist expertise. This includes an important focus on simulation as part of wider CPD, allowing the radiographer to prepare and develop competency with the tools and in an environment similar that deployed in the workplace.

5.4.2 Approach to standards

A 2008 study[59] identified the potential for European-wide core CPD provision for radiography practitioners. Standards are currently set by regulators within individual countries. The literature also suggests that CPD is used a vehicle for skills development and broadening of roles – CPD is used to provide training in new areas, in additional to ensuring competence to meet existing standards. Cross sectional imaging (CT and MRI) was the most popular area for CPD training although training in digital imaging and trauma were also much sought-after.[60]

[58] Higher Education Network for Radiography in Europe: http://www.henre.co.uk/

[59] The continuous professional development (CPD) requirements of radiographers in Europe: An initial survey. Gill Marshalla, Vytenis Punysb, and Anne Sykesc, Radiography Volume 14, Issue 4, November 2008, Pages 332-342

[60] The continuous professional development (CPD) requirements of radiographers in Europe: An initial survey. Gill Marshalla, Vytenis Punysb, and Anne Sykesc, Radiography Volume 14, Issue 4, November 2008, Pages 332-342

5.4.3 Accreditation of CPD

The Australian Institute of Radiography (AIR) approves courses and activities in line with their professional standards. In the UK, the College of Radiographers provides for the accreditation of CPD events such as conferences, study days and seminars, as well as that of learning products such as CD-ROMs and e-learning materials.

5.4.4 The assessment process

As in many CPD models, the recording and assessment process revolves around two types of approach - a credit-based option or a portfolio option – or a combination of the two.

- **Credit option:** This model is focused on a system of collecting a minimum number of points or credits within a specified timeframe. In Australia[61], successful completion of the CPD programme requires participants to claim a minimum of 36 credits over a three year period, with a minimum of 6 credits in any one year of the cycle and with the credits claimed in a minimum of 2 of the 5 CPD categories. CPD credit claims can be made via an online lodgement programme or via submission of a manual log.
- **Portfolio option:** Participants take responsibility for reflecting on their specific learning needs and designing the CPD activities that best suit those needs. There may be certain requirements in terms of showing participation in a number of different types of activities but it is primarily up to the participant to
- **Combined option:** This option combines the credit option with the portfolio option and allows participants to decide which system works best for them. For example in New Zealand, there are two options available for radiographers to gain professional development certification, allowing professionals to design an approach to meeting their professional development needs in a manner that best suits them. These are:
    - CPD Credit Option: A specified number of credits or points are awarded for a recognised professional activity. The professional activities have been divided into three main groups: formal educational Information and Technology activities; Professional Participation.
    - Portfolio Option: Allows participants to demonstrate their professional development in a style that best suits their requirements. The aim of the portfolio is to encourage participants to reflect on their professional practice and to develop a learning plan accordingly. This option requires participants to take responsibility for their own learning and development, to reflect on the work they are currently doing and to record, critique and evaluate their own performance.

In Finland, whilst all radiographers should maintain their own portfolio, the employer is also required to keep a record, as well as a plan for each employee working with medical radiation[62].

[61] Australian Institute of Radiography website: www.air.asn.au

[62] Higher Education Network for Radiography in Europe: http://www.henre.co.uk/

The Society of Radiographers in the UK has outlined a strategy to enable the Society to secure meaningful participation in CPD. The strategy sets out the obligations of the individual members, the responsibilities of the employers and the initiatives to be taken by the Society to achieve that aim. The strategy also outlines an online system by which the Society can accredit and monitor CPD activities undertaken by individual members. The first CPD audit in the UK will be carried out in February 2010.

5.5 Teaching

Points to consider in development of the Irish model for mandatory CPD:

- More strategic approaches to CPD which emphasise the entitlement of teachers and control of their own professional development within an agreed framework
- Voluntary systems of CPD are more prevalent.

5.5.1 Nature of the system

Despite the growing importance placed on CPD by the teaching profession, its representative organisations and governmental bodies, in most countries, CPD is not mandatory for teachers. There is however a growing expectation that teachers will engage in CPD activities:

- In Ireland, CPD is voluntary. Since the establishment of the In-career Development Unit (ICDU) in 1992, there has been significant expansion of in-service teacher continuing education, in which since 2006 the Teaching Council has played an advisory role to the Department of Education and Science.
- In most EU countries and Australia[63], CPD is not mandatory but there is an increasing expectation that it will be undertaken. This is reflected in the professional teaching standards
- In Scotland, CPD is now mandatory, since the national agreement 'A Teaching Profession for the 21st Century'.
- In the USA and New Zealand, CPD is mandatory. Undertaking CPD is linked to re-registration and/or career advancement. [64] The US No Child Left Behind Act placed a strong emphasis on demonstration of competency in a teacher's core academic subjects[65].

[63] "Standards of Professional Practice for Accomplished Teaching in Australian Classrooms" Australian College of Education., 2000.

[64] The Continuing Professional Development of Teachers in Wales: International and Professional Contexts. A review carried out for the General Teaching Council for Wales, by the Cardiff School of Education, University of Wales Institute, Cardiff and the PPI Group. January 2002

[65] Redesigning Continuing Education in the Health Professions, Board of Health Care Services (2010)

5.5.2 Approach to standards

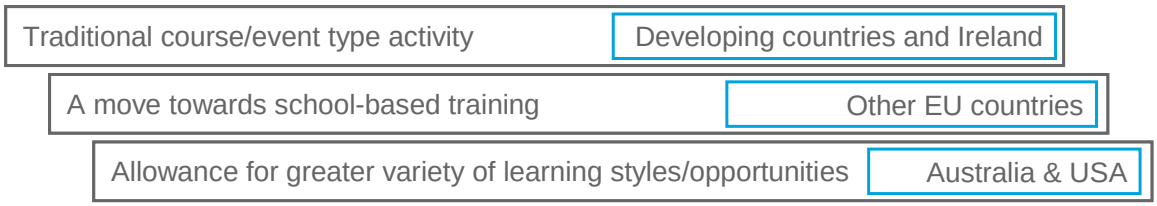
Review of standards for CPD in teaching show that these are broader than specific content matters or skills, but relate to the teacher's role in a holistic way, covering areas such as professional values, attributes and understanding. This also allows teachers to take a highly tailored approach to their CPD.

In England and Wales, the Training and Development Agency has a drawn up professional standards for the Secretary of State that articulate the professional attributes, knowledge and understanding and skills expected at each stage of a teacher's career. These form the basis for CPD. In Northern Ireland, the General Teaching Council has set out professional competencies for teachers in Teaching: the Reflective Profession[66], covering the areas of professional values and practice, professional knowledge and understanding, and professional skills and application. In Scotland, the standards and process are set out in 'Teaching in Scotland: Professional Review and Development'.[67] Whilst in the US states are primarily responsible for setting standards, the National Board for Profession Teaching Standards (NBPTS) provides guidance.

5.5.3 Accreditation of CPD

Other than in Australia (where innovative practice is in place) internal and external accreditation of CPD is not apparent. An increasing trend towards a collaborative model of delivery was identified, involving teachers, schools and CPD providers. Three principal types of CPD activities were identified as shown in Figure 4.2:

Figure 4.2: Principal Types of CPD Activities for the Teaching Profession



5.5.4 The assessment process

The amount of CPD required is either precisely specified (New Zealand and USA) or, more generally, is left to individual teachers and schools to decide. Monitoring of CPD can be characterised as:

- ***Permissive***, allowing for self-management by schools and teachers (European Union, France, Scotland, Malaysia, Ireland);
- ***Regulatory***, with strong involvement from the state or other bodies which may be tied closely to appraisal (Australia), promotion and re-registration (New Zealand). It is unclear, however, to what extent this monitoring is effective in practice.

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[66] General Teaching Council of Northern Ireland website: www.gtcni.org.uk

[67] Published January 08, 2004, available on www.scotland.gov.uk

The nature of CPD in all these countries is one which is strongly linked to classroom and professional needs that reflect state education policies. This is true of developing countries as well as the European Union, North America and Australia. In some countries, however, more emphasis is placed on personal and experiential development (USA, Australia); these are generally the countries which allow for a greater variety of learning activities to comprise CPD. Other than in the USA and to a certain extent Australia, there is no requirement upon teachers to systematically plan any CPD activity. The same picture is apparent in relation to recording any professional development which is undertaken.

CPD for teachers may be provided in one of the following ways, or in some combination:

- Largely through in-house delivery (the main tendency throughout the European Union);
- Mainly by government bodies or agencies, including higher education (Malaysia, Ghana, Korea, France and New Zealand); and
- A variety of providers with an increasing trend for them to be working together in partnership (USA, Australia and Ireland).

5.6 Aviation

Points to consider in development of the Irish model for mandatory CPD:

- There is an international regulatory framework for the ongoing education requirements, with which country level regulators work
- Failure to complete mandatory CE results in loss of flying privileges, rather than loss of license
- The approach to competency assessment is based on flight activities and therefore simulates on the job conditions to assure the quality of professionals
- The onus is on the professional to maintain an up-to-date record of training, which must be available for assessment.

5.6.1 Nature of the system

The International Civil Aviation Organization (ICAO), a UN Specialized Agency, is the global forum for civil aviation. ICAO works to achieve its vision of safe, secure and sustainable development of civil aviation through cooperation amongst its member States. ICAO provides a global regulatory framework for the ongoing education requirements in the aviation industry.

A pilot is certificated to fly aircraft at one or more named privilege levels (e.g. recreational, commercial) and, at each privilege level, rated to fly aircraft of specific categories. Pilots have a requirement to demonstrate 'recent flight experience', undertake physical checks, undergo flying skills checks and undertake continuing education. Failing to meet these requirements results in loss of flying privileges, rather than loss of license.

In the U.S. a pilot certificate is issued by the Federal Aviation Administration (FAA). The federal pilot certificate does not expire, but to maintain certain flying privileges, pilots must demonstrate recent competence and experience[68]. In Canada, licenses are issued by Transport Canada. Each member nation in the EU has responsibility for regulating their own pilot licensing. This is done by the Irish Aviation Authority in Ireland and in the United Kingdom licenses are issued by the Civil Aviation Authority (CAA).

5.6.2 Approach to standards

The ICAO codifies the principles and techniques of international air navigation. It oversees the development of universally accepted standards known as Standards and Recommended Practices, or SARPs. SARPs cover all technical and operational aspects of international civil aviation, such as safety, personnel licensing, operation of aircraft, aerodromes, air traffic services, accident investigation and the environment. Country level regulators work within this framework. The European Aviation Safety Agency (EASA) provides the European regulatory framework within this context which are transposed into national regulations, with some national variation. The rules applicable to flight crew licensing are the national rules of EU member States, however these are in accordance with the EU and International standards.[69]

5.6.3 Accreditation of CPD

The nature of the aviation profession means that quality assured and accredited training is of critical importance. Indeed, the regulator also tends to take on the accreditation role. In each of the geographies examined, the national regulator approves training organisations and courses, and authorises licensing examiners and examinations.

All flight training in Ireland must be carried out at either at a Flight Training Organisation (FTO) or a Registered Training Facility (RTF). FTOs conduct flight training (aeroplane or helicopter) approved by the Irish Aviation Authority for both private and professional licences and ratings, however, intending students should check directly with the FTO for the specific courses offered by them. Registered Training Facilities (RTFs) are individuals, clubs or companies which are registered with the Irish Aviation Authority to provide training for the private pilot licence (PPL) and associated ratings only. [70]

The IAA also accredits Flight Simulators and Training Devices (FSTD). This includes evaluation and approval for initial or renewal qualification certificates for all training devices located within the State, and selected devices overseas. IAA issues user approval certificates for all training devices for which credits may be sought.

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[68] Redesigning Continuing Education in the Health Professions:

[69] EASA website: http://www.easa.europa.eu/flightstandards/

[70] Irish Aviation Authority: www.iaa.ie Regulation > Flight Training > Flight Training Organisations (FTOs)

5.6.4 The assessment process

A commercial pilot's license is gained through completion of an approved course of either integrated or modular flying training, combined with a theoretical knowledge course. This requires a minimum of 150 hours flying. To be accepted on the course, individuals need to demonstrate sufficient knowledge of mathematics and physics in order to understand the theoretical aspects. A full Airline Pilot's License (ATPL) is issued, normally for 5 years, on successful completion of the theoretical examinations, 1,500 hours flying time and a medical test. The age limit for a commercial pilot's license is 65 years. Knowledge and experience gained in military flying can be credited towards relevant requirements.

A common theme in all geographies is that the onus is on the pilot to maintain a log book or record of their flying experience and training, which must be available for assessment. For example in the UK, details of all flights made as a pilot must be kept in a reliable record acceptable to the CAA. It is the pilot's responsibility to maintain this record. The CAA re-issues a license to pilots holding a valid medical certificate, renewed every year, and a validated certificate of rating for a specific aircraft type/ class. Revalidation requires demonstration of professional flying skills and knowledge through "learning profiles checks". Where a pilot is employed, revalidation is carried out every 6 months on a flight simulator specific to the type/class of aircraft relevant to the pilot's operating requirements. Flying experience is checked, through the record log. A minimum of 12 hours flying time and 12 take-offs and landings is required. The examiner is normally employed by the airline and is accredited by, and acts on behalf of, the CAA. Self-employed pilots take a full test in an aeroplane with a CAA examiner every 2 years at their own expense.

5.7 Accountancy

Points to consider in development of the Irish model for mandatory CPD:

- CPD is mandatory across the profession
- There is a global framework for standard setting, and the overall approach to CPD consistent internationally rather than tailored at state level
- There is a strong emphasis on documentation and measurement of the outcomes of CPD activities.

5.7.1 Nature of the system

The main accountancy professional bodies are the Association of Certified Chartered Accountants (ACCA)[71] and the Chartered Institute of Management Accountants (CIMA)[72]. The former focuses upon financial accounting and the latter on management accounting. CPD is a mandatory requirement across the profession.

Any member who fails to comply with the CPD requirements will be referred to a panel of CPD assessors who will determine what action to take (CIMA) or referred to a disciplinary process (ACCA).

5.7.2 Approach to standards

The International Accounting Education Standards Board (IAESB), an independent standard-setting board within the International Federation of Accountants (IFAC)[73], sets the CPD standards for the industry. IFAC is the global organisation for the accountancy profession. Professional bodies then adopt the IFAC standards and declare their approach and materials compliant with them.

5.7.3 Accreditation of CPD

The CIMA CPD Product Accreditation scheme recognises and promotes products and services that benefit CIMA member's mandatory requirement to engage in ongoing CPD. The scheme is designed to accredit any relevant product or service that can provide a quality and valuable learning resource to CIMA members, giving them a 'stamp of authority' that the course is of suitable quality and will assist in their development.

CIMA also accredits a range of university courses. CIMA distinguishes between its product accreditation scheme and its other collaborations with universities. Whilst the former is described as 'part of the accreditation of education, prior learning and universities' the collaborations are described as "very high quality, specifically selected, primarily globally focused products, that should cover the whole range of members' expectations if they wanted the CPD to be tied to a higher education institute".

ACCA has an approved employer route, which they consider to be an output-based option. This option allows CPD to be provided through an approved employer, generally the employer provides for the member, evaluating their development needs, providing them with development opportunities and taking them through appraisal where their performance is reviewed on a regular basis. In this way, all development is focused on the job role and achievements.

[71] ACCA website: www.accaglobal.com

[72] CIMA website: www.cimaglobal.com

[73] IFAC website: www.ifac.org

5.7.4 The assessment process

CIMA requires members to formalise their CPD activities using the CIMA Professional Development Cycle. Members are responsible for assessing their development goals, selecting activities, and designing their CPD programmes. This approach aims to maximise the benefits of CPD by evaluating their learning outcomes and defining their progress towards career aspirations. CIMA has developed a range of products and services including reading materials, online planning tools, journal archives and training courses, with many available at no charge to members. CIMA has grouped them under the banner of CPD Solutions to help members locate and benefit from all the resources available to them.

Central to CIMA's CPD offering is the CPD planner; an electronic tool that aims to help members assess their own CPD requirements through 'gap analysis'. The CPD planner perceives areas of development that have not been covered and then depending on individual member's needs and ambitions, the member can choose new areas and topics for development. The planner covers ten different skill areas including management skills, technical skills, soft skills and others.

Members are required to keep CPD records (which include evidence of activities and outcome) for a minimum of three years on a rolling basis. CIMA selects a random sample of its membership to audit each year, which may be weighted to focus on particular cohorts e.g. those with high levels of responsibility.

The ACCA offers a flexible approach to participation in CPD, by offering three routes[74]:

- The unit route, in which a member is required to complete 40 relevant units of CPD each year, where one unit is equal to one hour of development. Of the 40 units, 21 units must be verifiable whereas the other 19 can be non-verifiable. Members have largely chosen this route which offers an input-based approach to CPD measurement.
- The approved employer route, in which ACCA recognizes employers who follow good practice for people development and meet the organization's criteria for approval. A focus upon competence and supporting individual learning and development is sought; as a result the organization allows members to achieve their CPD through their employer's development programme.
- The IFAC body route, in which the organization recognizes that some members also belong to another IFAC accountancy body and may prefer to complete CPD through their other membership body's programme, hence the member can follow just one CPD programme, rather than having to meet different requirements.

[74] "Approaches to Continuing Professional Development (CPD) Measurement", International Accounting Education Standards Board, Information Paper June 2008

As part of a CPD reform initiative, ACCA consulted its global membership via a survey and workshops about how they would like to see CPD developed. The feedback from the workshops indicated that members wanted to move away from measuring CPD by hours: *"there's always been this approach to CPD which was about how many hours you do, that sends people sulky almost."* However, the key message was that members wanted an international benchmark. Despite retaining one CPD route as input-based, the Association has encouraged a move from a purely points gathering exercise by requiring that any CPD undertaken is relevant to the individual's role.

Case Study: The ACCA Professional Development Matrix

ACCA's system provides an online tool called the professional development matrix (PDM) which takes members through the process of looking at their role profile and identifying the competences that they need for their role. An interesting feature of this PDM tool is that users are given an exercise about different ways of learning, and they are presented with some conclusions on their preferred learning style which is most effective for them before matching a suitable activity to their chosen competence. After this phase of the process, they develop a plan which involves prioritizing elements of their job role which need attention, and addressing any emerging areas in their job role which are new to them. The next phase is to complete a development plan with targets, activities, predicted results and output. Although the "unit route" offered does not mandate different phases of a CPD cycle, it does emphasize planning, activity and reflection through use of the PDM tool and in its communications.

5.8 Implications for the Irish CPD system for pharmacists

In this chapter we have presented our research into the approach to CPD in other professions, with healthcare and non-healthcare models explored. The purpose of this research was to identify significant trends and differences in approaches to CPD, in order to draw out the learning for consideration in development of the Irish pharmacy model. Some of the implications from our analysis in this regard include:

- The implementation of a globally recognised core competency framework that defines standards to underpin national CPD systems and the focus on an overall practitioner development cycle from undergraduate to advanced practitioner (Physiotherapy). Globalisation of professional standards is a trend that can be expected across most health professions, including pharmacy, and the Irish CPD system must ensure that it allows for close working with international peers and partners.
- The requirement to engage in a balanced mix of external, internal, personal learning and research and teaching CPD activities over a multi-annual cycle (Medicine)
- The development of peer and manager validation of self-assessments by professionals (Nursing)
- Outcomes-focused approach where expected outcomes from CPD activities are identified prior to their undertaking (Accounting)
- A move towards practical and tailored CPD targeting specific needs of teachers within the school environment (Teaching)

- An approach to competency assessment that simulates on the job conditions to assure the quality of professionals (Aviation)
- The use of CPD to extend the scope of competency in an evolving profession (Radiography).

6 The approach to standards, accreditation and assessment

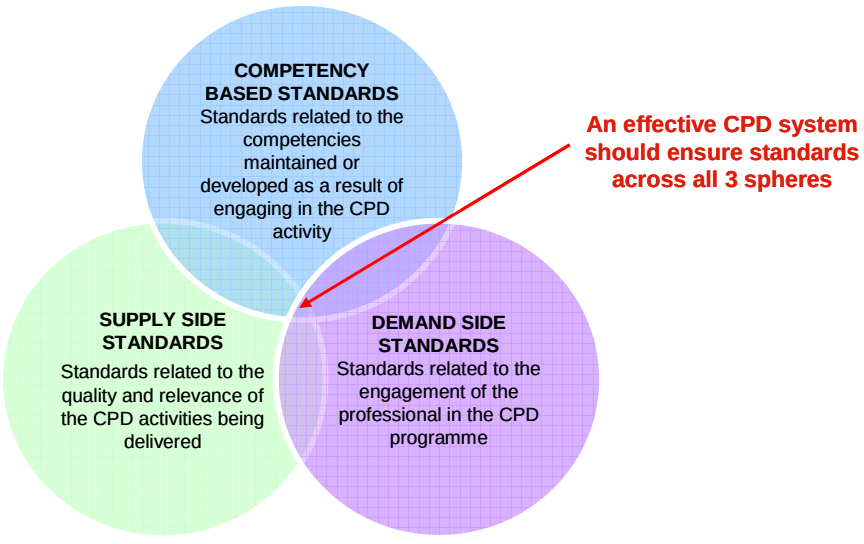
In this chapter we build on the overview of the international CPD models for pharmacy and other professions to look in more depth at the learning and implications for Ireland in the approach to standards, accreditation and assessment, including their links to incentives and penalties for participation. This allows us to identify key attributes that should underpin the development of the Irish system of CPD.

6.1 The approach to standards

The research into international models of CPD considered the approach to standards within each system, while examination of non-pharmacy models also highlighted a range of approaches in this regard. A core finding from all of this analysis is the importance of having clearly defined standards or responsibilities for the professional in relation to CPD. If this can be established and an appropriate level of buy-in achieved, it allows the CPD requirements to be integrated into the day-to-day responsibilities of a pharmacist in Ireland. Without standards to underpin implementation of CPD, there remains a danger that a CPD system will remain isolated from the mainstream activities of a pharmacist. This has potential to limit both its uptake across the profession and the extent to which it can actually assure, influence and improve the competency of the pharmacist.

There are three different approaches to the setting of standards related to CPD, as shown in Figure 6.1, with examples of how each has been adopted in other countries provided below. However a successful CPD system should verify standards to some degree across provision, engagement and overall competency and this should be an aim for a new CPD system for pharmacists in Ireland.

Figure 6.1: Approaches to the Setting of Standards in CPD



Research identified in Chapter 4 of the report highlighted how different international models have adopted each type of approach to standards:

- The first group, which we term supply side standards, focuses around verification of the quality of the CPD activities delivered as part of the programme. This formed part of the approach in Portugal where the Portuguese Pharmaceutical Society set standards for CPD activities in terms of definition of learning objectives; programme content and educators; applicability and relevance to practice amongst others (see section 4.2).
- The second group, termed demand side standards due to their focus on assuring engagement by the professional, are a core aspect of the CPD system established for pharmacists in the UK. The Royal Pharmaceutical Society of Great Britain published new standards for mandatory CPD which came into effect from 1st March 2009 which stipulated requirements in terms of: maintaining a record of CPD with a minimum number of entries per annum in line with good recording practice; recording how CPD has contributed to the quality or development of practice using the Society's CPD framework; and being able to submit the CPD record to the Society on request. (see section 4.7)
- The third group, competency based standards, involves the provision of a framework of specific competencies that members must address in their CPD, usually involving a mix of generic and profession-specific (Friedman and Woodhead, 2008)[75]. In some cases professional bodies offer a range of competencies from which members can select those most relevant to their particular role, while in others, particularly where the emphasis is on proof of competence, a set of core competencies are prescribed which must be covered by members. An example of the competency based approach is apparent in New Zealand, which established a competency framework based on seven competence standards against which pharmacists were assessed (see section 4.4.)

A key aspect in implementing all of these types of standards is the degree to which they are monitored. Ideally a system should ensure that development activities are of sufficient quality, that the professional sufficiently engages in the process and that the outputs of CPD relate directly to his/her competency. However while ensuring standards or some common understanding is in place across all three categories is important, there are inevitable resourcing consequences attached to monitoring. An overly onerous system will also discourage buy-in from the profession. It is to this challenge of monitoring the compliance of CPD with standards and assessing engagement in CPD that the study now turns.

[75] Friedman and Woodhead 2008

6.2 The accreditation of CPD

Accreditation is the process by which a private association, organization or government agency, after initial and periodic evaluations, grants recognition to an organization, site or programme that has met certain established criteria[76] As detailed in Chapters 4 and 5, the research indicates two approaches: accreditation of providers and accreditation of activities. Accreditation of individual activities is currently more widespread. The structures and processes established for CPD accreditation systems of providers vary from country to country:[77]

- In the **US**, ACPE accredits providers. Other approval processes exist (e.g., by State Boards) for individual activities.
- In **Canada**, the provincial regulatory authority and/or the Canadian Council for Continuing Education in Pharmacy accredits CE programmes for pharmacists.
- In the **Netherlands**, the term accreditation refers to approved CE activities
- Entire CPD programmes can be accredited in **New Zealand**
- In **Finland**, each of the providers has set their own standards and accredits their own activities.
- In Australia, the PSA is authorised to accredit providers of CPD.

The CPD system for pharmacists in Ireland will have to designate clear responsibility for accreditation of providers and/or activities. This will be further examined in the chapter on governance and management mechanisms later in this report. There was consensus across a wide base of stakeholders on the need for both formal and informal CPD activities to be recognized, including work-based learning. This will require the specialist knowledge of representative groups within the profession to help identify where activity represents a valid form of CPD. A system where providers are accredited alongside formal CPD activities and guidelines on eligible informal activities would therefore be appropriate.

The acknowledgement and accreditation of CPD should also facilitate international recognition of the pharmacist's learning. A model like the European Credit Transfer and Accumulation System (ECTS) offers a potential approach to cross-border recognition. The International Pharmaceutical Federation (FIP) has played a key role in encouraging consistent international approaches to CE and CPD[78] and it will be important to liaise with this organisation to ensure that accredited CPD activities can be recognized outside Ireland.

[76] Council on Credentialing in Pharmacy, USA (2006)

[77] International Trends in Lifelong Learning for Pharmacists, Annelies Driesen, PharmD, Koen Verbeke, PhD, Steven Simoens, PhD, and Gert Laekeman, PhD. Am J Pharm Educ. 2007 June 15; 71(3): 52. PMCID: PMC1913290

[78] Changing a profession, influencing community pharmacy, J.W. Foppe van Mil, Bente Frokjaer, Dick F.J. Tromp, January 2004

6.3 The recording of CPD

Most mandatory systems require professionals to prove that they have participated in an appropriate amount of CPD activities. The definition and measurement of 'an appropriate amount' of CPD varies significantly between sectors and countries, although all countries except for Great Britain and the province of Ontario have some variation of a credit points system. This means that pharmacists are required to collect a minimum number of credit points in a defined period of time, usually 3 to 5 years. These credit points are typically a reflection of the time spent on an approved CPD or CE activity (for example, attending a 1-hour lecture results in 1 credit point).

However the manner of recording and measuring this CPD participation by professionals has been changing. Early professional body CPD policies were primarily based on inputs, involving recording hours spent on CPD or collecting 'points' based on hours and the nature of the activities. However in recent years output-based systems of measuring CPD have become increasingly apparent. Such systems are based on the provision of evidence which shows how practice has developed or improved due to participation in CPD. Both approaches, and their advantages, disadvantages and applicability to the Irish context, are considered in further depth in the sections below.

6.3.1 Input based measurement systems

As noted above, the recording and measurement of CPD has traditionally been done by inputs: the quantity of hours spent doing CPD, or the number of points or credits accrued from participation in CPD events. Registrants usually have to build up a certain number of hours/points/credits from a list of approved courses and activities. The presumption behind input-based requirements and measures is that as long as professionals are carrying out a certain amount of CPD, it will ensure that they remain abreast of developments within their profession and that their competencies retain their relevance.

A prime example of an input-based measurement system lies in the existing approach to continuing education for pharmacists in Ireland where it is recommended that each participates in a minimum of 30 hours of continuing education per annum. Outside of pharmacy, the existing ACCA CPD scheme for accountants requires all holders of practicing certificates to do at least 35 hours of CPD per year, of which 21 hours must be spent on acceptable, structured courses.

Dependence on input-based measurement by professional bodies has notably reduced in recent years. It is increasingly recognized that simply recording the time spent on CPD does not necessarily ensure that anything has been learned, or that CPD will lead to any change in practice. The value of such activities tends only to be verified via the supply-side standards discussed in section 6.1. There is also a growing acceptance that a professional's training and development needs vary significantly depending on their competencies, position, employment environment, etc and that more tailored and relevant responses to meeting their actual learning needs are now essential. To facilitate this, a process of reflection and review is required alongside delivery of learning and this stands as a key component of any effective CPD system.

There has been some move to make input-based systems more reflective of the impact of CPD activities on practice. Some professions therefore award more credit points to activities that are more likely to have a substantive impact on practice, such as activities that require participation, active thinking and contribution or those that include an assessment component. More passive, didactic types of CPD activity attract fewer credits in this approach. While this provides some weighting of activities in terms of their relevance, it remains insufficient to establish the exact link between CPD and practice. In a climate of increased accountability and external pressures, professional bodies are therefore seeking further evidence that the profession's competency is developing in line with the evolving environment.

6.3.2 Outcomes-based measurement systems

CPD systems for pharmacists and other healthcare professions are turning to output-based measurement techniques that attempt to gauge the impact of CPD on the competency of practitioners and hence patient outcomes. This of course is the ultimate goal of an effective CPD system for the health professions but implementation of an effective outcomes-based approach is complex. It depends on developing accepted definitions of the core competencies within the profession and then on subjective judgment as to how these competencies are developed via the CPD activities. Note: if however, there is a research component put in alongside CPD with both hard endpoints and surrogate markers, over time, there can be trend analyses and logistic regression analyses performed to name a few, which will provide evidence of improved patient care.

This places significant onus on the individual to reflect on the impact of CPD on their working life, which requires development of a new way of thinking across the profession. This makes the exercise highly subjective, although introducing a peer and/or manager review component can provide additional validation[79]. The subjectivity and lack of clarity on CPD outcomes has led to some resistance to the implementation of output-based measures, with perceived cost (including the time required for self, peer and manager reflection) and reluctance among professionals to be "tested" on their competency cited as barriers to its introduction.

However use of output measures for CPD is rising quickly among UK professional bodies[80]. Good examples include the UK CPD systems for accounting (ACCA), physiotherapy and nursing, with all placing focus on impact on practice (see section 5.7). There are various outputs of CPD, and deciding which one(s) would be most useful to measure, and would give the most accurate and revealing results, is complex. A professional body has to identify the object of CPD before attempting to decide which output would be most appropriate to measure. Two key sources of difficulty with measuring results in a medical context have been identified:

- Lack of development of measurement methodology: with appropriate methods of results measurement not available

[79] Continuing professional development in pharmacy, Michael J. Rouse, American Journal of Health-System Pharmacy, October 2004

[80] Approaches to Continuing Professional Development (CPD) Measurement, International Accounting Education Standards Board, June 2008

- Complex expert clinical practice cannot be easily broken down into component parts and therefore measurement of the quality of practice as a whole is difficult, and may be impossible.

Within pharmacy there is also evidence of development of an outcomes–based approach. The CPD programme in New Zealand and the Learning and Practice Portfolio (LPP) option of the Professional Development and Assessment Programme (PDAP) in British Columbia are both based on patient outcomes, which require pharmacists to demonstrate and provide evidence that they have applied what they learnt to their practice to benefit their patients.[81] From their previous programmes and pilots (RxCARE in British Columbia and ENHANCE in New Zealand) new systems for assessment of pharmacists' CPD have been developed. However the introduction of an output-focused approach in each geography has had mixed success as noted in sections 4.4 and 4.5, with a number of barriers faced by both regulatory bodies including:

- Complex expert clinical practice cannot be easily broken down into component parts and therefore measurement of the quality of practice as a whole is difficult, and may be impossible.
- The difficulties with moving pharmacists towards systems that require the documentation of practice-outcomes
- Motivating pharmacists to use a systematic process of planning, implementing and evaluating their CPD on an on-going basis
- Developing criteria against which CPD can be assessed, and
- Developing a credit system that 'rewards' application of learning in practice in both the direct and indirect patient settings.

6.3.3 A portfolio-based recording approach

An outcomes based system of recording CPD is the ideal scenario for pharmacists in Ireland. It would emphasize the overall focus on patient outcomes and link this to the CPD activities being delivered. However the difficulties experienced in finding a means to successfully measure and validate outcomes is problematic and significant behavioral changes required across the profession to ensure that such a system operates effectively. Validation of these assessments would also require a strong role for peer or management assessment. However, the characteristics of the pharmacy profession, with a substantial base of community pharmacists operating in isolated work environments, would make it difficult to implement. One way of linking this would be to analyze the prescription data base of each pharmacy and divide into two: the constant areas of disease that the pharmacist sees all the time and therefore should be maintaining competency in that area (CPE) and secondly, the "not seen all that often" which would form the actual CPD activities in terms of pushing the new boundaries.

[81] Approaches to Continuing Professional Development (CPD) Measurement, International Accounting Education Standards Board, Information Paper June 2008

If there is a robust and appropriate periodic competency centred audit and assessment process, the importance of being able to measure and validate outcomes on an ongoing basis is less critical (by doing that above, then this would be achievable.). What is important however is that the system supports reflection on the outcomes on practice as a result of CPD activities. This can be done via a portfolio based approach which would require that the professional records CPD activities undertaken and reflects on the outcomes in practice. The portfolio system does not necessarily require a measurement of hours, points or credits, but should reflect a balance of CPD activities together with their perceived impact on competencies and practice (the nature of this balance is discussed in further depth in Chapter 7).

Definition of competencies will be required to assist this process, but work is already ongoing to establish competencies for the pharmacy profession in Ireland. There is evidence that such a portfolio based system can be successful, with Ontario having had this approach in place for 13 years. It works in Canada because it stands alongside a strong audit and assessment component, and the key attributes required in this regard are the subject of further discussion below.

6.4 Audit and assessment

6.4.1 Overview of audit and assessment processes

The approach to audit and assessment of CPD is central to ensuring that professionals are meeting the standards and requirements set. However, it is also one of the most complex elements of designing and implementing an appropriate CPD model. Some common problems relating to monitoring compliance with CPD requirements include:

- Stakeholder buy-in;
- Designing a system that is effective in ensuring overall compliance across all, or most, registrants;
- Finding sufficient resources to implement an effective monitoring system; and
- Accommodating the increased complexity of CPD, particularly self-managed activities in which professionals are participating.

Stakeholder buy-in can be an important differentiator of effective implementation of CPD. If professionals understand and accept the potential benefits of CPD for themselves, their profession and their patients or clients, they are much more likely to make the effort to understand the requirements and take the appropriate measures in terms of assessing, delivering and recording CPD activities. If, on the other hand, professionals do not see the benefits of CPD to their sector or their patients/clients, they will view it as another bureaucratic obligation that does not add real value to their work. Communication is thus a key aspect of any assessment process to assure compliance with CPD requirements.

The main monitoring systems that are currently in place are:

- Requiring ***submission of records or a portfolio*** demonstrating CPD activities that have been undertaken;
- Annual ***auditing of a sample*** of the Register or auditing a larger proportion of the high risk categories of registrants, but still on a random selection basis;
- Submission of a ***declaration of compliance*** on a cyclical basis, typically annually (such as in the UK where pharmacists sign a declaration to undertake a certain amount of CPD annually);

6.4.2 Submission of CPD records or portfolio

The cost implications of a substantive cross-profession auditing system together with the acceptance that professionals will require different development programmes to meet their unique needs means that most CPD systems place significant reliance on self-assessment for monitoring activity on an ongoing basis. This is particularly critical as we move towards more outcome-based systems (as the individual is in the best position to determine how learning has impacted upon practice) and has been further facilitated by the development of online tools and resources.

This has led to the requirement for pharmacists to maintain CPD records or portfolios having become established as the main ongoing recording system. Australia, British Columbia and Ontario in Canada and New Zealand (Pharmaceutical Society of Australia 2003; College of Pharmacists of British Columbia 2006 and Pharmacy Council of New Zealand 2006) all use self assessment against defined competence standards via a portfolio-based system which is linked with revalidation and re-licensing.

Some professions are very prescriptive about the format for recording and submitting CPD participation information. They dictate a strict template, record sheet, form or professional development report, a deadline for submission and offer no options on how it should be submitted, manually or electronically. Physicians in New Zealand are required to maintain a development report that includes their employment history, a log book of their CPD activities, evidence of their reflective statements, verification of practical hours and evidence of professional peer review.

Other professions are less formulaic in their approach and leave it to the professional to decide on how they want to maintain and present their records (hard copy, electronically or online). Until recently, pharmacists in the UK could record their activities either online, on paper or on a free-standing personal computer. There was no strict template for recording CPD activity. The CPD system for pharmacists is presently in reform and new systems are currently being introduced. Some professions have introduced advanced systems for recording CPD activity. These can include comprehensive online systems with remote access that allows professionals to update their records real-time through a bar code system. There are a variety of different ways of designing and managing input into a central database system.

This development of personalized portfolio tools that reflect CPD's contribution to the individual's particular needs is thus a major trend. Professions are increasingly requiring their members to set their own curriculum, changing the nature and scope of monitoring and compliance. This highlights the merit of a portfolio-based system of recording CPD being assessed on a qualitative basis (rather than a points system) in terms of how it demonstrated that the pharmacist's particular needs are being met.

The approach to reviewing CPD records or portfolios tends to rely on a system of sampling a proportion of professional records each year, such as in the geographies of:

- the Netherlands, where CE completion records must be submitted with application for licence renewal.
- Australia, portfolios are reviewed by random audit.
- New Zealand, where CPD portfolios are controlled and reviewed at random
- Northern Ireland, where a random selection of professionals must submit evidence of CPD activities or a portfolio, with this then graded in terms of compliance.
- In most US states, there is random audit of CE completion records.

While this represents a practical approach, there is a danger that it can fail to capture a sufficient number of registrants to be truly effective. To maximise the value of the resources deployed on sample auditing, some regulatory bodies have elected to target particular high risk groups, particularly those that seem least engaged in development activities and in interacting with the wider profession. However there is also a risk that such an approach further alienates these individuals, creating a perception that they are being unfairly targeted, and could result in them becoming disenfranchised.

The role of the peer or manager to validate recording of CPD is a further interesting dimension. In Nursing in the UK, a supervisor must verify the self-assessment undertaking. Research also reinforces the value of peer and collegial interaction in CPD, although ensuring that the support infrastructure is in place to facilitate this is critical[82]. An interesting parallel development to the establishment of a CPD system for pharmacists in Ireland is the work currently being undertaken to move towards a more outcomes-based approach in nursing, with a proposed focus on peer and manager review alongside self-evaluation. There is significant scope for shared learning as both systems develop, although the tendency for nurses to work in teams facilitates peer assessment to a greater extent than in, say, a community pharmacy setting.

In line with the experiences of other models, it is important that a portfolio-based approach to recording of CPD is a central component of the Irish CPD system moving forward. This should be available for submission on request and will be able to demonstrate engagement in a balance of CPD activities of the profession and reflections on the outcomes on practice. Providing evidence of ability to meet practice standards in this way, it will provide a platform for a robust system of practice review with peer involvement, as further described below.

[82] The role of collegial interaction in Continuing Professional Development, Anna R. Gagliardi, Frances C. Wright, Michael A.B. Anderson, Dave Davis. Journal of Continuing Education in the Health Professions, 27(4):214-219, 2007

6.4.3 Competency based auditing

While maintaining records and portfolios is an important aspect across CPD models, a truly outcomes-focused approach will require assessment of competency of the professional. Indeed the primary objective of the introduction of a CPD system for pharmacists in Ireland is to assure competency across the entire profession. This requires more than a check on participation in CPD activities and there is a need for a wider audit process that assesses the competency of the professional in line with defined standards.

As noted above, much of the 'auditing' that is undertaken focuses on periodic sampling of professional's CPD records or portfolios. New Zealand also has a mandatory self-assessment exercise every 5 years. However it is in Canada where a robust approach to external auditing of the competency of the profession has been adopted:

- ***Examination based***, where pharmacists are tested on their clinical knowledge. This is the case in British Columbia, where all practicing pharmacists are required to participate in an audit once every six years with one-half of all registrants participating after each 3 year cycle. This can involve a three hour, open book examination that serves as an indicator of pharmacy practice knowledge and problem solving skills
- ***Practice review***, where in addition to an examination pharmacists demonstrate competence via simulated work-based scenarios. This is the system adopted in Ontario, where a sample of the profession is selected for a day long audit session. It also includes an educational component on the approach to ongoing CPD and links to a remedial programme of action if required.

The latter system has significant attributes and has been able to secure significant buy-in across the profession in Ontario. As detailed in Section 4.5, the fact that the practice case studies are developed by peers, with assessment also undertaken by peers, means that there is ownership of the process by the profession. It is highly competency focused, recreating patient facing situations, with a strong remedial programme in place to assist those for whom issues are identified. Although covering only a small proportion of the profession in each practice review audit, the risk of being called to undertake the review appears to be sufficient to ensure compliance with CPD requirements. It allows the portfolio system to avoid quantitative measurement of CPD as noted above.

However some issues have also been identified in the Ontario system around the appropriateness of the practice review to pharmacists working in different settings. The practice scenarios tend to relate to the community pharmacy environment, risking disengagement by pharmacists working in hospital or in industry. This highlights a need to build some flexibility into any practice review process introduced in Ireland to ensure that those working in different settings are faced with scenarios relevant to their roles and responsibilities. The small size of the audit sample in Ontario (3-4%) is also a concern and appears to be a result of the significant resources required to support remedial action. A study by Winslade, Tamblyn, Taylor, Schuwirth and Van der Vleuten (2007)[83] developed a holistic framework for practice review that was performance based and acknowledged the significant influence of external factors on performance. This examined motivating, enabling and reinforcing factors for key stakeholders in pharmacy practice, including its link to the wider healthcare system. This has potential for use in the overall auditing and practice review system for the Irish CPD model and this theme is further examined in Chapter 10 of this report.

Ireland can learn from these lessons in developing a practice review approach to assessment that meets the needs of the profession. A framework that takes account of external factors influencing performance would place the work of pharmacists in an important wider context. A larger sample size would be desirable in Ireland to provide maximum assurance to the public. This would provide additional incentivisation of ongoing engagement in CPD by increasing the expectation of being called for a competency-based practice review. Full coverage of the profession over a set period in this process would be desirable, although undertaking a peer practice review exercise for all pharmacists over, for example, 5 years would require 800-900 participants per annum. Further investigation is required with regard to the feasibility of meeting the costs of this substantive exercise and it is unrealistic for such comprehensive assessment coverage to be introduced in the initial years of implementation. This reflects a steady state condition only. A more feasible approach would involve a review of the CPD portfolios of one-fifth of the profession each year, with a sufficient proportion of this base then called to undertake the practice review process. The need to demonstrate the undertaking of adequate CPD activity added to the expectation of being selected for a practice review should then be sufficient to make the profession compliant to overall CPD requirements.

6.5 Incentives and penalties

The most common incentive for pharmacists to undergo CPD or CE is the renewal of a license to practice as a pharmacist in the country. This is generally the last resort however, and if a pharmacist is demonstrating non-compliance with CPD requirements the general options are:

- Follow a remedial CPD programme (e.g. Pharmacists in the UK, Ontario)
- Take an examination (e.g. Pharmacists in Portugal)
- Register in a category that requires supervision

[83] Intergrating Performance Assessment, Maintenance of Competence, and Continuing Professional development of Community Pharmacists, Nancy E. Winslade, Robyn M. Tamblyn, Laurel K. Taylor, Lambert W.T. Schuwirth, Cees P.M. Van der Vleuten, American Journal of Pharmaceutical Education, February 2007

- De-register

The majority of models that we have studied for this review use some system of registration, certificate or licensure to provide a framework for managing the system of continuing professional development. Criteria are set for ongoing renewal or updating of membership as well as the minimum entry requirements. Evidence of meeting CPD requirements is commonly required for recertification or revalidation of professional registration.

The central motivation of the Irish system must be improved patient safety and assuring the competency of all practising pharmacists will be the central driver in this regard. The ultimate sanction of de-registration must therefore always be available for those that cannot demonstrate the required competencies. However a remedial process should also be available to help pharmacists address any issues preventing them from practising effectively prior to such a step being taken.

6.6 Implications for the Irish CPD system for pharmacists

This analysis of the approach to standards, accreditation and assessment generates significant learning to inform the development of the Irish CPD system for pharmacists. The implications for the system include:

- There is an increasing focus on definition of formal standards to underpin delivery of the Continuing Professional Development programme. These are usually linked to mandatory standards of CPD, as in the development of standards for CPD by the Royal Pharmaceutical Society of Great Britain in March 2009. Another approach involves basing standards around a framework of specific competencies that members must address in their CPD. These competencies are usually a mix of generic and profession-specific. The CPD system for Ireland should verify standards to some degree across provision, engagement and overall competency and this should be an aim for a new CPD system for pharmacists in Ireland.
- The recording system for CPD has been developing, with early professional body approaches primarily based on inputs, that is, simply recording hours spent on CPD or ‘points’ based on hours and the nature of the activities. However there has been a growing move towards output-based systems of measuring CPD and this should provide a closer link to evidence which shows how practice has developed or improved due to participation in CPD. Taking this learning on board, the core ongoing assessment mechanism should involve maintenance of a portfolio that places the onus on individual reflection and evaluation of outcomes, with a role for peers in supporting and reviewing experiences, and periodic sample assessments providing external assurance of competency.
- The approach to audit and assessment of CPD is key to ensuring that professionals are meeting the standards and requirements set. The main monitoring systems that are currently in place are: annual auditing of a random sample of the membership; submission of a declaration of compliance on a cyclical basis; or submission of evidence in the form of records on a cyclical basis to prove compliance. Monitoring systems are inevitably highly resource intensive but are an essential component in ensuring that CPD systems remain focused on ensuring the highest quality standards in practice within the profession.

- The most appropriate approach to assessment for Ireland should involve CPD portfolio and competency-based practice review components. A system of CPD portfolio review should be introduced that targets one-fifth of the profession each year (ensuring full coverage over a 5 year period). The selection of a sufficient proportion of this sample for practice review, a process developed by peers which recreates patient facing scenarios to assess competency. This would help to incentivise engagement in CPD (due to the expectation of being called to undertake this process).
- The most common incentive for pharmacists to undergo CPD or CE is the renewal of a license to practice as a pharmacist in the country, with the penalty thus attached to non-compliance being the loss of the right to practice. Remedial support should also be available for those with issues in meeting competency standards.

7 The CPD delivery model

Defining the overall approach to standards, accreditation, recording and assessment puts in place a framework from which delivery of the CPD model can then be considered. We begin by looking at the initial need for the delivery model to focus upon assuring competency as part of longer-term development of CPD as a support system for practitioner development. We then examine the specific needs of pharmacists operating in different settings. The operational issues in achieving a balance across different CPD activities, a blended delivery model and an outcomes-focused approach are then discussed.

7.1 An initial focus on assuring competence

In designing the delivery model for CPD, there are two key parameters which must influence its development:

- Pharmacists' right to practice will be derived from a ***single register*** system.
- The first priority of the system must be to ***assure competency*** across the entire profession.

The single register system means that a CPD system must, first and foremost, put in place the conditions to ensure that every pharmacist in Ireland demonstrates a required level of clinical competence and that at all times are competent to operate in a patient facing role.

In achieving this, it is also important to acknowledge in the CPD system that pharmacists working in different settings have varying characteristics and needs. For example, the competency requirements of a hospital pharmacist can be complex and relate to particular specialist expertise necessary for an individual role. The development of specialist competencies is an important aspect of the practitioner development model which is further detailed in section 7.2. However it is also important that pharmacists from this and the community setting are involved in shaping the standards essential for any pharmacist in a patient facing role to ensure that they reflect a broad framework of clinical competence. This will underpin the development of an effective CPD system, ensuring that it provides a basis for assuring competency and a platform for practitioner development.

To assure competency, it is important that the competency standards must be clearly defined and communicated to the profession, supports and controls should be put in place to ensure that the entire profession engages in CPD to meet these standards, and CPD activities should reflect what is needed to maintain this required level of competency. For those in non-patient facing roles, support should also be put in place via the CPD system to allow them to maintain the required competencies and remain on the Register.

In the initial set up phase, in order to assure the competency of the single Register of Pharmacists, the practice review will take account of a general framework of professional practice that must be applicable to all practice settings. This would provide a foundation for a system to evolve over time that can focus on defined or distinct competencies in line with different practice settings. As there already are well-defined specialisations within the hospital practice setting, the system should be able to take account of these features in a relatively short timeframe. It is understood, however, that the CPD activities within the new framework will allow for such specialisations to be pursued and developed and the proposed system will not will be constructed in a manner that would hinder or curb such developments.

7.2 Supporting practitioner development

A core component in the CPD delivery model is the way in which CPD activities are developed and provided. There is concern that presently structured education for the pharmacist in Ireland ends at the point of graduation. A core objective of all CPD systems is to put in place a lifecycle approach to learning that ensures the initial skills and expertise required to enter a profession are built upon continually along a defined career pathway.

There is a tendency for some continuing education and CPD systems to stand alone from the initial learning that developed the competency to allow the individual to enter the profession. This represents a flawed approach however, and competency should naturally evolve during the professional career using the same principles that underpinned the development of the initial skills and expertise. The ICCPE has played an active role in involving appropriate academics in the design and delivery of education and training to pharmacists. As a new CPD system is being developed, it is important that this link to academia is built upon and underpins a collaborative approach to practitioner development that extends throughout the career of all pharmacists.

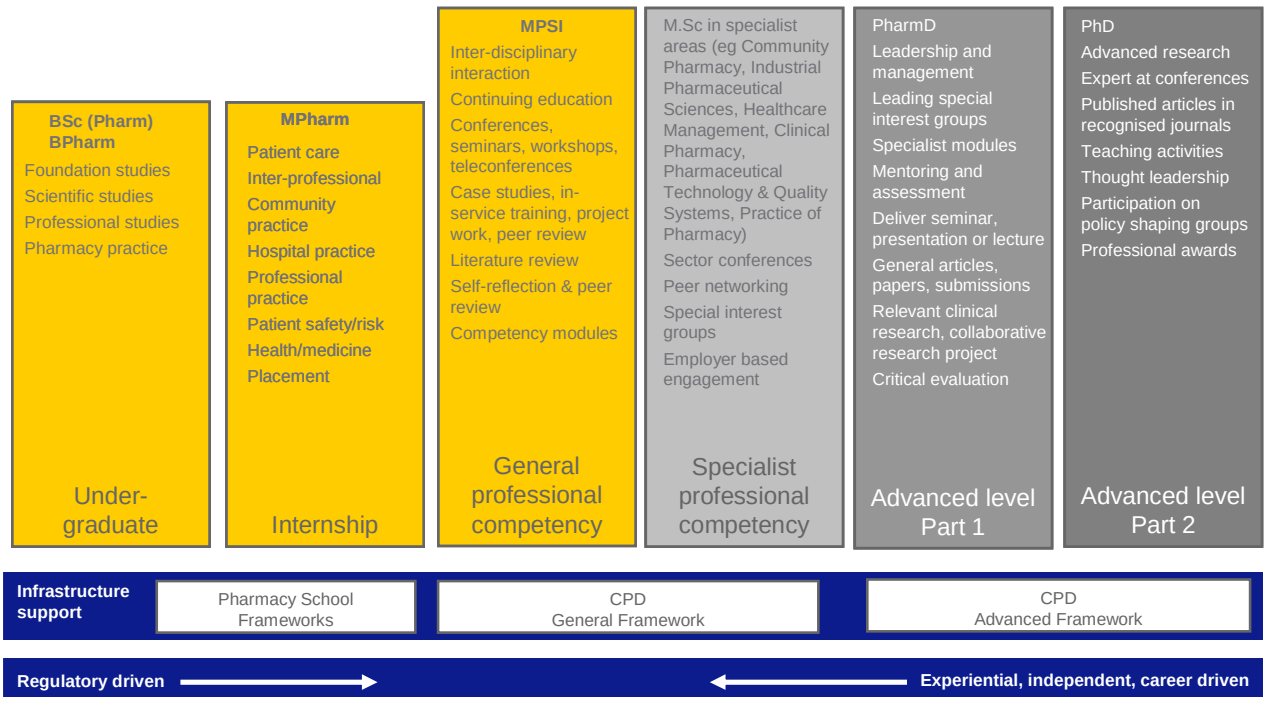
The nature of this role will have to be established as the system develops. There are cultural barriers to academia delivering shorter, more succinct packages of learning (although moves to a more modular based approach to higher education is helping to counteract these concerns) and more informal learning that takes the participant out of the classroom setting, meaning that making higher education institutions the sole delivery agents of CPD activities may not offer the most effective approach. Awarding the status of CPD provider to one sole institution may also have the unintended effect of alienating the other institutions, while it is also likely that such an approach infringes Irish competition law. We will need a model that makes partnership and collaboration an essential component of the system and we propose a potential approach via an Institute model in Chapter 8. There is a strong desire of all existing providers of undergraduate and postgraduate pharmacy education in Ireland to be actively involved in the new system, and a way should be sought to harness all of this commitment and expertise as we move forward.

Figure 7.2 highlights a model of practitioner development, based on our consideration of good practice across other models. This naturally extends the structured academic postgraduate and undergraduate learning to a continuing learning development curve throughout the pharmacist's working life.

The first challenge, as noted in section 7.1 above, is to establish a system that delivers on the generalist competency requirements that will assure required standards for patient-facing roles across the profession. This is represented in the diagram via the yellow shaded boxes, ensuring that all on the Register have reached this level by providing them with a portfolio of CPD activities that will allow competency to be maintained. The practice review process will be focused upon demonstrating generalist competency requirements via practice-based scenarios. This will be reinforced by the CPD portfolio system which will record and include reflections on participation in the types of CPD activities that help to maintain this level of competency.

The practitioner development model envisages using the different learning modes (taking full advantage of distance and e-learning channels) to move the professional on from undergraduate qualifications through general and higher level development processes. In essence it represents a move from a rigid, regulatory based system driven by achieving registration to a more experiential, independent and career driven system where the individual develops in line with needs and pursues specialisms within his/her chosen field.

Figure 7.2: Overarching Framework for Practitioner Development[84]



[84] This model is based on the existing pre-registration approach which separates Bachelor and Masters qualifications. The model may evolve based on the recommendations that will be contained on the report on the PEARs Project (Pharmacy Education and Accreditation Reviews) due in May 2010

The model of practitioner development aligns closely with the development of the superintendent pharmacist position as the key resource within every retail pharmacy business in Ireland. The additional legislative requirements, discussed in Chapter 2, place an onus on the superintendent pharmacist to ensure that all pharmacists under his/her management have the requisite knowledge and skills. The CPD system should help to shape this function and allow it to represent the attainment of excellence within the profession.

The model also supports the strong focus on development of specialist competencies within the hospital pharmacy setting. As highlighted earlier in this chapter, the competencies of a hospital pharmacist are closely linked to the particular role that he/she performs. The CPD system must take account of the specialist competencies that need to be maintained and developed within hospital pharmacy. It should recognise and build upon the existing activities that support sharing of peer knowledge (e.g. via special interest groups) and dissemination of research relevant to practice (e.g. via journal clubs). There is already significant infrastructure in place in this regard (supported by the HPAI) and embedding this within an overall approach to practitioner development across the CPD system will be important. Indeed this focus on development of specialist competency within this setting is an area in which learning can be drawn in the development of competency across the profession.

The development of specialist competency is also framed by legislation. For pharmacists working in industry, a 'qualified person' must meet the requirements of EC directives 2001/83/EC and 2001/82/EC in order to be responsible for the manufacture of proprietary medicinal and veterinary products. For pharmacists working in hospitality and community pharmacy, the need to develop specialist competency through education and training has been recognised as far back as 1985, Council Directive 85/432/EEC[85] required "coordination of the requirements for training in pharmacy specialities…which can entitle a person to use a specialist title".

This high level model of practitioner development should form the basis of the CPD framework put in place to underpin an appropriate system for pharmacy in Ireland. It should balance the need to maintain a minimum level of competency across the profession with an advanced framework designed to facilitate the pursuit of excellence and development of specialisms throughout the career path. Over time, this might ultimately lead to the establishment of an award of a Fellowship in recognition of professional achievement (a theme further discussed in Chapter 8).

[85] Council Directive 85/432/EEC, 'Concerning the coordination of provisions laid down by Law, Regulation or Administrative Action in respect of certain activities in the field of pharmacy' of 16 September 1985

7.3 Balancing the needs of different pharmacy settings

The pharmacy profession involves pharmacists working in four principal settings: community, hospital industry; and academia. In considering other models elsewhere and drawing on our consultation with representatives from each of these settings, it is clear that there are different motivations and needs from each interest group from a CPD system. However there is also a desire to see a system that recognises the commonalities across the profession and the benefits that can be shared from the expertise and experience of those working in different settings.

The challenge in designing an appropriate CPD system is therefore being able to offer sufficient flexibility to meet the needs of pharmacists working in different settings. This means mapping the needs in these different settings against the learning that is required to maintain and develop competency alongside an appropriate system that can measure and assess the way in which this is being developed. It also means recognising that the different situations and settings in which pharmacists operate can have an impact on the level of engagement in CPD. Some community pharmacists operate in quite isolated environments with significant business pressures and research has shown that levels of participation in CPD tend to be lower than for hospital pharmacists[86]. More intensive, locally accessed support infrastructure may therefore be required to support this cohort. Figure 7.3 provides a broad overview of the needs within the differing settings from a CPD system.

Figure 7.3: Balancing the Differing Needs of Pharmacists in the CPD System

[86] 'Scottish pharmacists views and attitudes towards continuing professional development', Ailsa Power, B.Julienne Johnson, H.Lesley Diack, Susan McKellar, Derek Stewart, Steve A.Hudson, September 2007

Of course, the central objective that links the needs in all these settings is the overall focus of patient safety. While it is critical to design a system that provides the flexibility for pharmacists to continually develop regardless of the environment in which they practice, the overarching driver of all activity must be improved patient outcomes. The system must ensure a minimum level of competency across the profession while encouraging the pursuit of excellence based on the specialist needs in the individual setting.

The CPD system should also focus on the needs of pharmaceutical assistants. The Register of Pharmaceutical Assistants is also held by PSI and this role is highly important in delivery of effective pharmacy services. There is a natural synergy in grouping appropriate CPD interventions for pharmaceutical assistants with those of pharmacists and the system should incorporate the requirements of both roles.

7.4 Balance across different CPD activities

CPD should build upon continuing education to provide a more holistic approach to learning and development that includes formal, informal and incidental learning. While continuing education is one important component of CPD, it has tended to be didactic in nature. Indeed research has shown that continuing education in isolation is of limited value as a vehicle of continuous improvement and ongoing learning. Jones, Edge and Love, for example, conducted analysis of an educational intervention for community pharmacists on a methadone programme but found little impact on pharmacist attitudes or practice[87]. There has been a global shift across many sectors to build on this more passive type of learning with more proactive interactive on-the-job learning that is directly relevant to the professional's everyday circumstances. Thus, CPD is now increasingly incorporating a large menu of options, activities and learning approaches to help maintain, develop and increase knowledge, problem solving abilities, technical skills or professional performance standards.

Some examples of activities include pre- and post- self-assessment, conferences, seminars, lectures, problem solving activities, mentoring activities (giving and receiving), multi-disciplinary meetings, job rotation, secondment, clinical and professional supervision, case study discussions, shadowing, home study, in-service and a variety of other activities. Indeed an effective CPD system should have as a core principle the recognition of any activity that develops the competency of the practitioner.

In order to put some structure and order on the expansive nature of CPD activities, a system of categorisation is often deployed, tailored to the needs of the particular sector. The method of delivery is often used to categorise different types of CPD activities. Figure 7.1 provides examples of how CPD categorisation takes place in some geographies.

[87] 'The effect of educational intervention on pharmacists' attitudes to substance misusers', Lynn Jones, Janet Edge and Alix C. Love, Journal of Substance Use, October 2005

Figure 7.1 Categories of CPD activities

Medicine – USA	Physiotherapists – New Zealand	Nurses - British Columbia
• Live activities - Conferences, seminars, workshops, teleconferences, etc. • Online learning – Webcast • Enduring materials – printed, recorded, audio-visual • Journal CME – Peer review, designated professional journals • Test Item writing – research, drafting, writing questions for exams	• Work-based – Case studies, in-service training, project work, peer review, journal club • Professional activity – Quality improvement activities, presentations, lecturing, assessor / auditor / adviser, mentoring • Formal education – Conferences, seminars, courses, postgrad, articles, papers, submissions • Self-directed – Distance learning, observation, develop course materials	• Continuing Education – workshops, conferences, clinical updates, rounds that target clinical treatment • Literature review – Critique relevant professional journal, participate in journal club • Academic courses – applicable to practice of nursing • Teach – Educational seminar, presentation or lecture • Write – Journal article, chapter in a book, etc. • Research – relevant clinical research, participate in collaborative research project, complete masters thesis

This type of categorisation exercise can be beneficial both for the professional body and / or regulator and for the participant as it provides structure and clarity around the nature and type of CPD activities available and completed. In some places, a prescriptive approach has been adopted whereby participants are required to complete a certain amount of CPD for each category. Other models use a more flexible approach, whereby the participant determines which CPD is most appropriate to respond to their particular identified learning needs. There is also a number of combination models that set parameters and guidelines for the type of CPD that should be completed but do not set strict requirements.

The categorisation of activities assists in the process of maintaining a CPD portfolio, a tool used across most CPD systems to document the activities undertaken and demonstrate. The focus on development of a portfolio is also important to ensure a balance in the type of CPD activities undertaken by a professional. A system that relies purely on reflection from on-the-job experiences is likely to be as limited in value as the purely educational approach noted above. A pharmacist committed to his/her development as a practitioner should share good practice within work, network across the profession, attend relevant conferences, keep abreast of the latest research and up-skill via appropriate courses. There should also be a clear idea of the outcome that each activity will bring and a focus on reflection of how engagement has influenced the ability to practice. Hence it is important that any CPD system ensures that there is a balance of different types of development activity being accessed, and that the focus remains on its impact on competency and practice.

7.5 Blended delivery model

The main channels of delivering CPD are through face-to-face contact, online tools and distance learning. Traditionally, the majority of CE was delivered through **face-to-face** learning in various forms, including attending or delivering conferences, lectures and seminars in addition to on-the-job learning. In some systems learning is concentrated in specific locations. In Finland, for example, there are specialised pharmaceutical learning centres for training pharmacists like the Palmenia Centre for Continuing Education. In recent years there has been a shift towards a blended approach to learning incorporating face-to-face, online and distance learning, with these channels further explored below.

Distance learning is the provision of education through print or electronic communications media to professionals engaged in learning at a time and place of their own choosing and at a distance from a presenter, facilitator or tutor. The education may be web-based or fixed-format (e.g. CD-ROM). Distance learning provides a convenient, cost effective and accessible channel of delivery of CPD. Often, distance learning does require prior approval to ensure that it is appropriate and accredited to count towards a participants' CPD requirements.

Online learning is one type of distance learning and the popularity of online learning or e-learning is growing steadily as internet accessibility is improving and more and more people are increasingly accessing technology and internet literate. So-called 'e-CPD' often provides the means that professionals can access specific areas of interest through new forms of CPD; interactive multimedia content, peer-to-peer communities and just-in-time access to relevant information. E-learning can be delivered in a variety of ways:

- **Courseware:** Web or CD Rom based materials for self-study - these can include simulations and other interactive modules;
- **Virtual lectures:** 'Webinars' and webcasts either delivered in real time (synchronous) or achieved for download (asynchronous) - Synchronous lectures allow interaction with other students and lectures;
- **Virtual labs / simulators:** Access to virtual simulators is a cost-effective means of testing designs while some remote access physical resources are currently being developed; and
- **vCommunities of practice:** Chat-rooms, message rooms and email can all contribute to learner support infrastructure and allow peer to peer knowledge exchange.

There are some good examples of how online learning has been deployed to facilitate access across the pharmacy profession, such as the streaming of CPD presentations via the internet by the University of British Columbia in Canada (see section 4.5). However perhaps the most significant development with regard to the deployment of technology in CPD has been the introduction of online CPD portfolio tools that record activities and facilitate reflection on how learning has influenced practice. The development of an online professional development matrix by the ACCA for the accountancy profession highlighted the potential of using online interactive tools to assess competencies and development needs and address them via CPD (see section 5.7). The system introduced by the Royal Pharmaceutical Society of Great Britain (see section 4.7) has attracted praise for this reason and allows a flexible and light touch approach to CPD for pharmacists that retains a focus on outcomes. There is broad stakeholder consensus around the need for an Irish system to display such attributes and this emphasises the key role that online systems should play in the development of an appropriate CPD model.

However use of the internet to deliver CPD is constrained by access to and use of technology across the profession. Interactive tools and provision of e-learning opportunities must therefore be offered in tandem with form-based systems and face-to-face education and training. While online portfolio tools are proving more robust and effective in measuring and shaping development of competency, there remains a need to offer options such as handwritten log books and paper-based portfolio tools for those with ICT accessibility of capability issues. This mixed approach has been deployed in Australia where pharmacists can choose between a tailored online recording tool and hard copy resources. In Ontario there is a more open system, with pharmacists permitted to record learning in any format. While a blended approach is important in the interim however, use of online resources should be actively encouraged and a fully online CPD portfolio system should be a key objective over time.

7.6 Placing the onus on measuring CPD outcomes

The two defining features of how CPD is recorded are firstly, *who* is responsible for recording CPD activities and submitting CPD records and secondly, what format or system is used to collect and collate records. There are primarily two main entities responsible for recording, maintaining a record and reporting CPD activity:

- **The professional:** The system of self-reporting is currently a common approach to recording and reporting CPD activity. Under this system, it is the professional's responsibility to record all of the CPD activity in which they engage either manually in a folder or logged electronically on their own computer or through an online system. They are required to maintain a record of their participation (the length of time for which records have to be kept varies) and to report their CPD records regularly before a specified deadline or on request from the professional or regulatory body.

- **The provider of CPD activity:** Some professions use a system whereby the providers of CPD are required to keep a record of who attended various CPD activities and this is fed into a central database. Participants who engage in some form of approved self-directed CPD can notify the professional body of any extra measures in which they have been involved. Reporting of self-directed may have certain terms and conditions, for example approval may be required in advance of participation.

The key to an effective system in Ireland will be sufficiently structuring CPD activities to ensure that an appropriate balance is accessed by the professional while ensuring that the main driver of engagement is development of competency and improvement of practice. The system should place an onus on the professional to demonstrate how learning is resulting in them being more effective in the way in which they deliver their services and care. As long as this can be demonstrated, the type of learning and development experienced should be relatively open and flexible. This is the case in the CPD model for pharmacists in Great Britain, where there are no requirements on the type of CPD activities that participants must report (other than a minimum of 12 entries a year), as long as the activities contribute to the pharmacist' professional development. However there are rigorous processes in place to ensure that outcomes do result and are clearly articulated via this system. The key learning in this regard is a structured approach to reflection on the outcomes for learning, and further positive examples are provided in the new GP Continuing Medical Education Diary for GPs in Ireland (see section 5.2) and the approach to self-reporting and reflection for physiotherapists in Ontario (see section 5.1). An outcomes-based reflective tool that allows for a wide base of relevant CPD activities should be a core component of a future Irish CPD system for pharmacists.

A simple application of a more outcomes-focused approach to delivery of CPD activities would require members to fill out questionnaires after each activity. These questions should relate to what value the CPD activity provided to support the members in improving their practice. Although this approach can provide a degree of support for individuals in their CPD, by itself it cannot ensure that those individuals are indeed keeping up their competencies. If the questions are sufficiently detailed, a small step towards supporting the ideal of ensuring competency may be achieved. If this is introduced alongside a reflective portfolio-based system as suggested in the previous chapter it reinforces the outcome-focus of the CPD system.

7.7 Implications for the Irish CPD system for pharmacists

In considering the nature of delivery of CPD in other models, there are a number of implications for the development of an approach for pharmacy in Ireland:

- Designing the delivery model for CPD must take account of the fact that pharmacists' right to practise will be derived from a single register system and that the first priority must be to assure competency across the entire profession. This means that a CPD system must, first and foremost, put in place the conditions to ensure that every pharmacist in Ireland demonstrates a required level of competence. The practice review process is based around this requirement, with peer developed practice-based scenarios used to assess competency.

- While the initial priority must be to assure competency, the delivery model must also place focus on practitioner development. A core objective of all CPD systems is to put in place a lifecycle approach to learning that ensures the initial skills and expertise required to enter a profession are built upon continually along a defined career pathway. Over time the CPD system in Ireland should balance the need to maintain a level of generalist competency across the profession with an advanced framework designed to facilitate the pursuit of excellence and development of specialisms throughout a career. The CPD portfolio will facilitate recording of and reflection on engagement in CPD activities that are most relevant to the needs of the professional, both in terms of practice setting and seniority of position.
- Pharmacy is a complex profession with professionals working in very different settings that include: community; hospital; industry; and academia. Balancing the needs of those working in different settings is a key challenge and one that requires recognition of the varying motivations and needs from each interest group. The central objective that links the needs in all these settings is the overall focus of patient safety. While it is critical to design a system that provides the flexibility for pharmacists to continually develop regardless of the environment in which they practice, the overarching driver of all activity must be improved patient outcomes.
- There are many different types of activities that can contribute to CPD and a key aspect of an effective delivery model is requiring a balance of different CPD activities in a professional's development. A system that relies purely on reflection from on-the-job experiences is likely to be as limited in value as the purely educational approach. A pharmacist committed to his/her development as a practitioner should share good practice within work, network across the profession, attend relevant conferences, keep abreast of the latest research and up-skill via appropriate courses. CPD is intended to focus upon how learning is applied rather than gathered and placing the onus on measuring CPD outcomes from these activities should be a key aspect of an effective CPD delivery model.
- A blended delivery model needs to be put in place that utilises available technology to its full potential. Use of e-learning to deliver CPD and interactive online portfolio and assessment tools has allowed a flexible approach to development that retains a focus on outcomes in other models. There is broad stakeholder consensus on the need for an Irish system to display such attributes and online systems should play in development of an appropriate CPD model. However, barriers around access and ICT competency mean that paper-based resources remain important in the short and medium term, and a blended model that allows use of these options is critical.

8 A vision and principles for the Irish model of CPD

In the preceding chapters we provided an overview of the nature of international CPD systems for pharmacy and other professions, highlighting learning to inform the development of the Irish system. We have also provided analysis on how these models demonstrate effective approaches to standards, accreditation, assessment and a model delivery for CPD. We can now build on this analysis by building a framework to underpin the development of the Irish model of CPD for pharmacists. In this chapter we define this framework, proposing a vision and core principles to underpin the system, considering the competencies that must be developed and maintained by CPD and describing the broad components that will comprise a successful Irish approach to CPD.

8.1 Vision for a CPD systems for pharmacists in Ireland

By drawing on the research undertaken and consultation with a broad cross-section of relevant stakeholders with an interest in the development of the profession, a vision can be defined for the role of a CPD system for pharmacists in Ireland.

Vision for a CPD system for pharmacists in Ireland focused on patient safety

- A system that assures competency across the profession to meet patient needs and demonstrates this competency to others
- A mechanism to allow for innovation and development in the role of the pharmacist
- A supportive, enabling and transformative system that meets personal and professional needs
- A flexible, user-friendly and contemporaneous system that is recognised by pharmacists as helping to support the way in which they practise their profession
- A system that rewards learning by professionals and provides accreditation that is recognised internationally
- A system that encourages and supports engagement with other healthcare professionals

8.2 Core principles for an effective CPD system

It is critical that the future Irish model of CPD for pharmacists is grounded in a series of core principles that make clear its purpose and relevance to the profession. These principles must be clearly communicated to all pharmacists and should serve as a central mechanism to build ownership of the system. From the research and consultation undertaken during the assignment, there is evidence from practice elsewhere and consensus across key stakeholders that the following core principles should frame the CPD system for pharmacists in Ireland in the future:

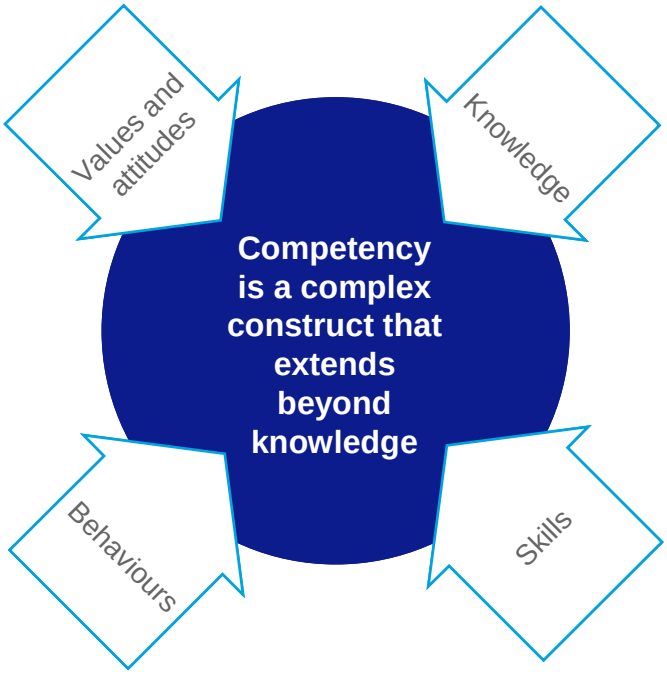
- A overriding focus on ***patient safety***, ***patient care and public welfare***
- Recognition that CPD focuses on a ***self-directed, ongoing, systematic and outcomes-focused*** approach to learning and professional development education
- Provision of a ***culture of support*** for the individual pharmacist in maintaining competence and developing as a practitioner
- ***Flexible but practical*** system with balance of learning over structure (formal, informal, etc) that demonstrates meaningful outcomes-based learner progression
- Meeting the ***needs of wider health services*** and supporting practitioner development
- Based on a ***career pathway for practitioners*** with improved patient outcomes and proven 'value-for-money'
- Ability to benefit and ***engage practitioners across all practice settings*** (including those working in community, hospital, industry and academic settings)
- ***Clarity of responsibility*** for delivering the four distinct governance functions: representing the profession; regulating the profession; accrediting CPD activity; and delivering CPD activity.
- A model ***referenced against best practice*** and based on learning from the experiences of other regulatory bodies
- ***Involvement of peers*** in the shaping of the standards and assessment systems and the CPD delivery model itself
- Engaging pharmacists by demonstrating the ***return on the investment*** of time in CPD activities
- An approach to CPD that allows ***international recognition*** of the activities in which the pharmacist engages
- ***Appropriate resourcing*** to ensure its effective deployment

In Chapter 9 we discuss appropriate approaches to implementation and a key step will be the revision, formalisation and acceptance of these core principles by pharmacists working across all practice settings. Once this is achieved, the principles will serve as key pillars of the model developed, ensuring that ownership across the profession is secured and the scope for disagreement on the way forward is minimised.

8.3 Linking CPD to competency standards

We have noted how the most effective CPD systems are those that are able to fully link and integrate activities into the wider maintenance and development of competency across the profession. CPD must always fundamentally be about the competency of the profession. However competency is a complex construct, extending beyond skills and involving knowledge, behaviours and values and attitudes, as shown in Figure 8.1 below.

Figure 8.1: Defining Competency Across a Profession



Source: Austin et al[88]

Taking these parameters and considering them in the context of pharmacy requires a series of core competencies for the profession. The PSI is commissioning a separate exercise to define a competency framework for the pharmacy profession in Ireland[89]. However in understanding the appropriate means and methods for a CPD system in Ireland it was also important to consider the competencies on which this system must focus. These are shown in Figure 8.2 together with the types of attributes that are relevant in each case.

[88] Continuous Professional Development: the Ontario experience in professional self-regulation through quality assurance and peer review. Z. Austin, D. Croteau, A. Marini, C. Violato, American Journal of Pharmacy Education 1997;61:117-26

[89] When the competency framework is defined following this exercise, this report should be reconsidered in the context of this output

Figure 8.2: Core Competencies for a Pharmacist in Ireland

Competency Theme	Associated Attributes
Professional practice	Skills, knowledge and attributes, patient care responsibilities, legal and ethical responsibilities, clinical reasoning and judgment, professional autonomy
Communications and networks	Communication, teamwork and consultative mechanisms, inter-disciplinary approach
Leadership and management	Vision, motivation, governance, strategy, innovation, service development, planning, performance, change, priorities, resources, standards, risk
Education and development	Mentorship, role models, peer to peer, delivery, practice education, wider policy understanding, relationships with other healthcare professions, building "communities of practice"
Research and evidence base	Critical evaluation, protocol review, evidence creation, development, supervision, partnerships
Reflection and assessment	Self-reflection, understanding of competencies, ability to assess peers, identification of learning needs, the inputs-outcomes model

These competencies reflect those identified by other pharmacy models and also take into account the views of the key stakeholders consulted. Peers will play a key role in the development of these competencies. The separate exercise to fully define these competencies will be able to build on this work to allow an in-depth competency framework to be put in place. The competency framework should then shape the focus of CPD activities in the Irish model, with support infrastructure in place to facilitate development for each competency and attribute.

8.4 Core components of a CPD model

With the core guiding principles and the overarching professional competencies defined, a foundation is in place to develop the primary components of an appropriate CPD model for pharmacists in Ireland. Linked by an overarching goal of patient safety, the components can be broken down into four primary categories as follows:

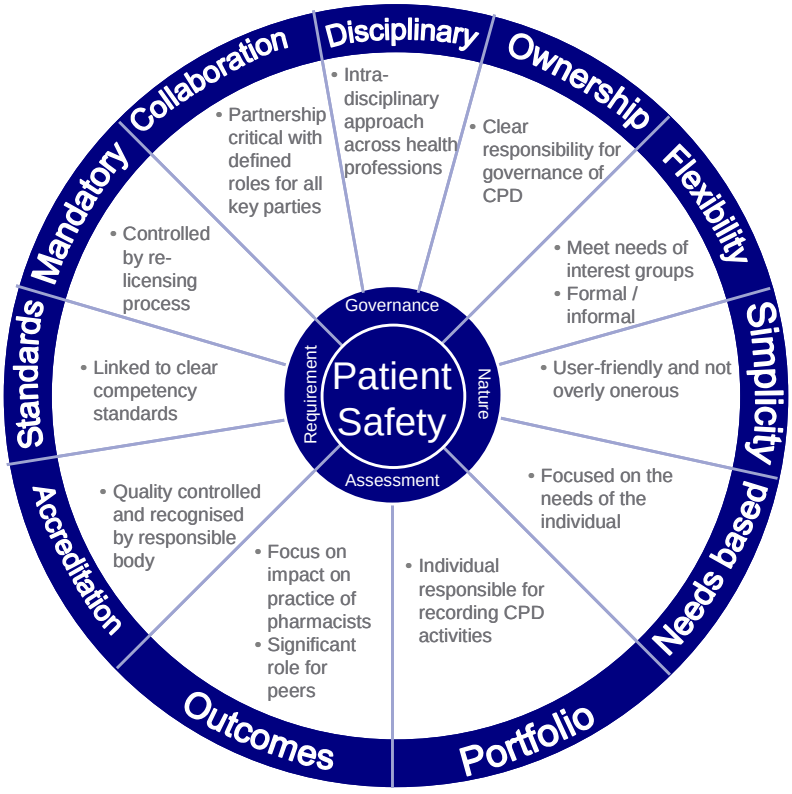
- ***Requirement*** – how engagement by the profession is to be ensured. This can be achieved via a mandatory system based on continued registration, adherence to clear professional competency standards, with the quality of CPD activities controlled and accredited by a recognised and responsible body
- ***Governance*** – putting in place a management structure and clarifying roles and ownership across the key stakeholders on whom long-term success of the CPD system will depend. This will mean assigning responsibility to appropriate organisations for designing, implementing, overseeing and monitoring CPD activity in Ireland.

- ***Nature*** – how the CPD programme is to be delivered. CPD activity must be focused on the needs of the individual, and this will require flexibility to meet the needs of pharmacists working in different settings (community, hospital, industry or academic). Simplicity must be a key attribute of the new system, avoiding overly onerous requirements or complex recording processes.

- ***Assessment*** – ensuring that the system is outcomes-focused with an approach to assessment that documents the way in which CPD activity is impacting upon practice and competency. This will require the ongoing maintenance of portfolios that record the CPD undertaken and the outcomes generated in this way, with access to these portfolios available to the regulatory body as and when required.

Taking these components together, we can build an overview of an appropriate CPD system for pharmacists in Ireland moving forward, as shown in Figure 8.3.

Figure 8.3: Primary Components of a CPD System



9 Structures for CPD governance, management and provision

In this chapter, we bring together the learning from experiences of CPD models for pharmacists in other key geographies and for other professions to examine the structures required to establish, implement, manage and deliver a CPD system. From this analysis, we draw out the implications for an appropriate approach in the development of an Irish CPD system.

9.1 Clarity on CPD governance roles

Any CPD system must be underpinned by strong structures for governance, management and provision. In effect these structures provide the link between the regulations that frame the profession, the CPD provision that develops the profession and the pharmacists that deliver products and services to improve patient safety and patient care. Although the structures used to manage and implement CPD systems vary, there are four important functions that make up the core components for delivery of continuing professional development:

- **Regulator:** The entity responsible for regulating the sector in the interest of protecting the public interest, enforcing pharmacy legislation and ensuring high standards of education and training among other functions.
- **Managing organisation or Institute:** The body responsible for developing, implementing, managing and overseeing the CPD system.
- **Accrediting body:** Organisation responsible for accrediting providers of CPD events and materials to ensure that the standard and quality of training being delivered by the training providers is of a high quality, is appropriate to meet the learning needs of the professionals involved and will lead to improvements in service delivery in practice.
- **Delivery agents:** The universities, schools, institutions or other organisations responsible for designing and delivering the training to the professionals, whether it is in a classroom, online, in a simulator, etc.
- **Representative bodies:** Organisations representing the different cohorts of the profession (e.g. community pharmacists, hospital pharmacists, pharmacists working in industry, academic pharmacists, pharmaceutical assistants). These are critical mechanisms for informing the CPD system on practitioner needs and in supporting the engagement of the pharmacist in this system.

As examined in Chapter 4, approaches to governance, management and provision vary across geographies, but one common theme is clarity of responsibility for delivering the four distinct governance functions. Great Britain has recognised the need for a greater separation of functions in this regard, moving from a system where the Royal Pharmaceutical Society of Great Britain had both professional and regulatory responsibility to one where the newly created Professional Leadership Body (PLB) is charged with delivery of CPD activities with the General Pharmaceutical Council assuming regulatory responsibilities. Canada, US and the Netherlands have created separate accreditation bodies for continuing professional development, while other geographies link responsibility for accreditation to the body responsible for registration (Portugal through PPS) or delivery (Great Britain where the College of Pharmacy Practice accredits activity against the RPSGB competency framework).

Devolving responsibility for delivery of CPD activities to an appropriate body has the advantage of simplifying the system (and accessibility to CPD) for professionals. It allows knowledge and expertise to be built up within an organisation which should improve the efficiency and effectiveness of delivery. However it also creates potential to alienate other potential providers of CPD activities and lose out on their valuable experience. Multiple provider models can function effectively if there is central coordination of activities. A final critical aspect in selecting an appropriate delivery agency for CPD is the need for provision to be under-pinned by a strong academic base. CPD should be seen as a natural extension of formal pre-registration learning and development prior to registration and isolating it from the expertise involved in developing and delivering the undergraduate and postgraduate qualifications required to register and practice will limit its effectiveness. Involvement of the higher education institutions who provide such PSI accredited programmes in the overall delivery model is therefore an important objective. In some professions (e.g. nursing and midwifery in Ontario), schools and colleges have actually been made directly responsible for delivery of ongoing CPD to alumni.

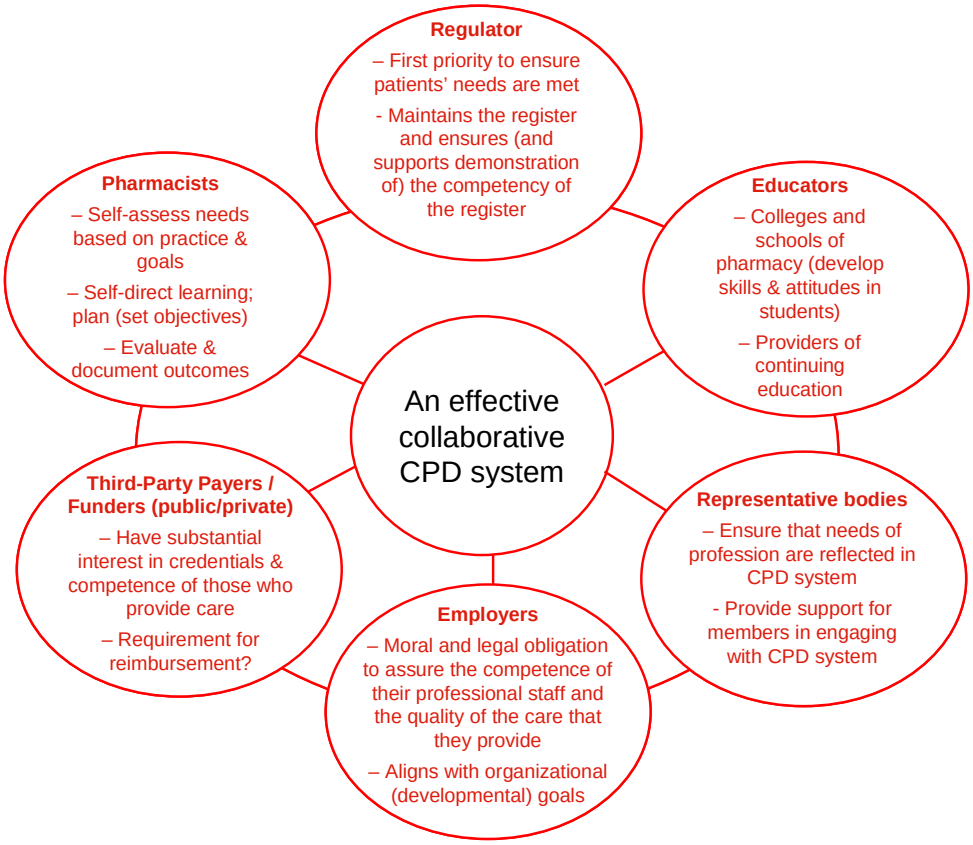
However, in this report we have highlighted the varying needs and characteristics of the pharmacists working in different settings (community, hospital, industry and academia). We have also noted the CPD activities that are happening within these settings to reflect the particular needs (e.g. peer networks, business association, inter-disciplinary teams, wider organisational training and development, bitesize courses, special interest groups, conferences, etc). The system must find a way to meet all these needs and recognise all of the different types of activities that contribute to practitioner development in each setting and to enable the transition of practitioners across the varying settings. While an academic institution may be in the best position to develop and deliver appropriate formal accredited education to the profession, multiple providers across a range of delivery agents may achieve greater buy-in from particular cohorts of the profession and provide interventions that can meet particular niche needs. The most appropriate system for Ireland therefore may be one which has a body with overall responsibility for management of the delivery system but does not directly deliver activities itself. Instead, it commissions or recognises the activities developed and delivered by other appropriate agents. This theme is further explored in the remainder of this chapter.

9.2 Importance of collaboration and partnership

The research indicates a major global shift towards greater collaboration and partnership in CPD governance, design and delivery. As understanding of lifelong learning grows, there is greater appreciation of how collaboration between academia, practice, industry, and government – both nationally and internationally - can be developed to foster its expansion. Collaboration plays a critical part in delivery of successful CPD models and mechanisms must be found to ensure that the relevant stakeholders work together effectively.

The starting point must be a clear definition of the roles of the key stakeholders. These can be broken into 6 key groups: the pharmacists themselves; the regulator; educators; representative bodies; third party funders; and employers. Each should have an important contribution to make to effective development and delivery of CPD, as highlighted in the diagram in Figure 9.1.

Figure 9.1: Key Stakeholder Roles in a Collaborative CPD System



In developing an appropriate system of CPD, these roles must be reinforced by a shared understanding of the overall objectives of that system. Contacts within all of the pharmacy CPD models researched have emphasised the importance of defining core principles that can be agreed by all key stakeholders. These are then used to underpin the development and delivery of CPD activities, minimising the risk of stakeholder confusion and disagreement by showing clear links back to agreed reference points. This has also been a key driver of progress in the development of CPD for nursing in Ireland, with the needs of a rapidly evolving profession referenced against an overall objective of improved patient outcomes and core principles to which all key stakeholders have reaffirmed their commitment.

9.3 Resourcing CPD activities

Although the CPD system should be driven by need in terms of improving patient safety, assuring competency and facilitating practitioner development, identifying an appropriate system cannot be achieved without some consideration with regard to how CPD activity will be resourced. This will have inevitable implications for how the system is rolled-out and delivered. From consideration of international models, there are four main ways in which CPD can be funded:

- ***Government-funded***: where Government provides direct funding to support a CPD system and associated activities.
- ***Membership-based***: where fees paid to the professional body are used to support the CPD system and associated activities.
- ***Fee-based***, where a fee is paid by the professional to access a particular CPD activity.
- ***Combination of these sources*** where, for example, a professional body might organise a course or a conference that is partly supported by its own membership fees, perhaps attracts some Government support to hold it, and charges members an additional attendance fee to cover the overall costs.

Our research also revealed industry sponsorship of a number of events that could contribute to practitioner development. Such activities are governed by legislation[90] and Codes of Practice and may be either commercial or educational in nature. These events present an invaluable part of the landscape for pharmacists in Ireland and their cost effective contribution to practitioner development, both now and in the future and should not be overlooked. Industry should be supported in efforts to focus more on general development led activities in preference to commercially focused initiatives. This might involve considering how industry delivered education and training is accredited within the CPD system and how the role of industry in this regard is recognised. An interesting approach currently being explored in Finland tries to allocate funding by encouraging industry to contribute to an independent CPD fund that could identify activities and report on the use of funds. Industry then gets acknowledgement in terms of sponsorship of the fund and associated programmes. The need to separate CPD from commercial interests and the perception of bias is essential for its credibility, but with sufficient control over industry involvement based on agreement of roles and mutual benefits this can provide a cost effective means of delivery.

The funding of CPD is a significant concern across stakeholders with an interest in the development of an appropriate system for pharmacy in Ireland. To build on the voluntary, input-based continuing education approach will require investment to ensure the tools, learning and other infrastructure are in place to ensure a holistic approach to practitioner development. Resourcing is therefore a critical issue that must be addressed in establishing the Irish system, as it influences characteristics including the scale of the CPD activities that can be supported, the deployment of tools and infrastructure to support the system and the robustness of the monitoring and assessment processes that underpin its delivery.

[90] Medicinal Products (Control of Advertising Regulations) Act 2007

9.4 Considering options for governance and resourcing

Bringing together the analysis of CPD governance and management frameworks, the need to facilitate collaboration and partnership and the resourcing of CPD activities, we can consider options for the development of the CPD system for pharmacy in Ireland. Having discussed the issues highlighted above with key stakeholders across the profession, 5 core options have emerged on the structures to underpin delivery of an effective CPD model. These options, and their advantages and disadvantages are further considered in Figure 9.2 below.

Figure 9.2: Options for Governance and Management Structures

Option		Advantages	Disadvantages
1	**Do nothing**	• No immediate cost implications in maintaining status quo (although could be longer-term cost implications due to diminished patient outcomes) • No potentially onerous obligations placed on the pharmacist to engage in CPD activities	• Would conflict with the legislation for an appropriate system of CPD • Would not address concerns over competency among those not currently engaging in CE activities across profession • Inability to demonstrate competency across the profession may lead to dwindling role for pharmacy in wider patient care • No focus on practitioner development which may impede further evolution of the profession
2	**System folded into the HSE**	• Clear funding structure as part of wider portfolio of HSE education and training • All activity will be linked to wider healthcare objectives • There will be a strong inter-disciplinary focus to development activities • Potential to use existing HSE local infrastructure and facilities to support delivery	• Limited focus on flexible and personalized system required to meet the diverse needs of individual pharmacists • HSE has no statutory mandate to provide education and training for pharmacists as it does for doctors and nurses • Potential for limited ownership and buy-in from the profession • Sole focus on maintaining competency rather than practitioner development • Limited relevance for pharmacists working in industry or academic settings • Issues around engagement with community pharmacists not employed by HSE

3	**Regulator controlled system**	• Clear link between registration and the CPD system • Regulator can construct CPD system around defined competencies	• Moves function of PSI beyond regulation and into delivery and outside area of core functions and expertise • Blurs line between identifying issues for development and continued registration • Potential for limited ownership and buy-in from the profession • Focus on maintaining competency and meeting minimum standards rather than practitioner development • Extent of CPD activities supported may be limited by funding by registrants
4	**Independent management and delivery body**	• A distinct body responsible for management and delivery of CPD creates a dedicated focus on the issue and identifiable contact point for the profession • Separates regulatory function from professional development body • Should facilitate ownership and buy-in across the profession • Single delivery body simplifies access to CPD by the pharmacist	• Dedicated body potentially more expensive than options 1-3 • Potential competition law issues if sole provider of CPD activities appointed • Will be difficult to meet the differing needs of pharmacists across the profession with a single provider • Would lack the infrastructure to facilitate local delivery
5	**Independent management body**	• Dedicated focus on development and management of CPD system – taking on a 'leadership' role for the profession • Separates accreditation from delivery in the CPD system • Should facilitate ownership and buy-in if a representative management board is put in place • Can bring in independent expertise to drive development of CPD system • A commissioning approach to CPD activities should generate efficiencies not available from direct delivery • Would facilitate a quality assured multiple provider model that could meet the differing needs of pharmacists	• Cost implications of supporting a dedicated management body could be significant and business case must be made clear • Reluctance to create any additional public sector structures in current environment • Clarity required on how a separate management body would be funded

Having considered the advantages and disadvantages of the principle options for governance, management and resourcing, we would recommend that a separate management body that does not get involved in direct delivery of CPD activities be selected as the preferred option. This displays the closest synergy with the guiding principles for a CPD model defined in section 7.5 and creates a focus on CPD that will help to drive patient outcomes across the profession. In effect it would create an 'Institute' type of model, with an expert body overseeing the management and delivery of CPD, accrediting activities by a range of providers, recognising engagement in CPD by individual pharmacists and providing direction on maintenance of competency and development of specialist expertise across the profession.

It must be acknowledged that the above comparative analysis has been undertaken without detailed analysis of cost implications. We have attempted to identify the exemplar high-level model from which full development can be further articulated. It is important however that once the nature of the separate management body and delivery model is established, this is fully costed to demonstrate overall value-for-money in comparison to the other potential options. A business case must be made for its deployment that makes clear that any initial public expenditure can be recouped through savings as a result of improved patient outcomes and patient safety and that over time, it can attain financial self-sufficiency.

The first step therefore is to define how this approach might be introduced, which we do by examining the development of an Institute model in the section below. Then, as attention turns to implementation in the next chapter, we consider the issues with regard to cost and funding that must be taken into account before establishment of an Institute proceeds.

9.5 Developing an Institute model

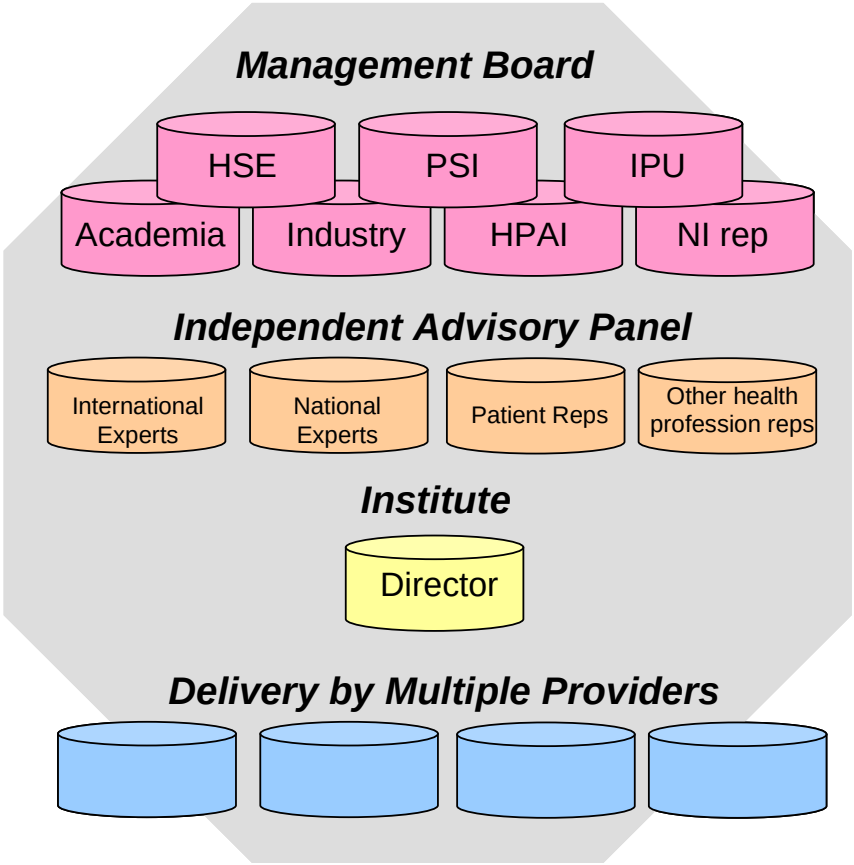
This learning should be reflected in a robust Irish model of governance, management and provision that designates clear responsibilities for the individual functions and ensures a collaborative approach to continuing professional development and moving the profession forward. This model would involve the regulatory body PSI controlling the regulation and registration process and defining the competency standards against which the CPD system would be framed. The CPD system would require a collaborative management structure that ensures buy-in and influence from all key stakeholders. The approach to provision should also ensure a balance of providers that can engage with pharmacists operating in different settings (including geographical settings) and a balance of different types of CPD activities.

Based on the research and the themes emerging from stakeholder discussions, we propose an Institute model (illustrated in Figure 9.3). This model would involve:

- A representative cross-section of stakeholders overseeing the management of the system to ensure ownership and buy-in and a 'needs-focus' to provision.

- An independent advisory panel with a strong inter-disciplinary focus, including international and national experts (e.g. a representative from a body such as the Irish Medication Safety Network) and including representatives from patients ensuring the focus remains on patient safety via practitioner development ties
- An Institute overseeing the management and delivery of CPD, funding and supporting appropriate provision and ensuring outcomes are generated by providers and assessing the practice standards of pharmacists
- Multiple provider system in place to ensure a balance of CPD opportunities is available (including specialist opportunities) meeting the needs of pharmacists working in different settings.

Figure 9.3: A Suggested Institute Based Approach to Management and Delivery of the CPD System



Establishing an institute to be responsible for overall management and delivery of CPD offers clarity to the profession and a dedicated focus on driving the CPD system forward. It could serve as the standard bearer for placing patient safety as the overriding objective across the pharmacy profession. An Institute would also facilitate the concentration of expertise within a distinct resource and could therefore serve as an important driver of research capability across the profession.

By facilitating and quality assuring different learning models and different providers the Institute will be able to put in place the conditions for assuring the competency of the profession and supporting further practitioner development. It would be responsible for ensuring that a portfolio of relevant CPD activities exists to meet the needs of those pharmacists in community, hospital, industry and academic settings. Indeed it would be expected that there would be distinct units within an Institute targeting delivery of effective CPD to those within these settings, with appropriate links to the relevant representative bodies. This would ensure that community pharmacists could help shape the CPD that is relevant to their particular situation, hospital pharmacists could do the same for those in this setting, with pharmacists in industry afforded the same opportunity. The Institute would also ensure that there was adequate focus on the development of the superintendent pharmacist and supervising pharmacist roles as well as the development of specialisations across the profession in addition to generalist competencies (in line with the practitioner development model outlined in section 7.2).

In this regard the Institute may look towards establishing a Fellowship system over time whereby it can confer Fellowships in recognition of attaining a particular level of expertise, experience or achievement. This could work on both an honorary and assessment based system, with such an initiative helping to reinforce the development and profile of the profession. This would help to build the profile of the profession and create key experts that can help to drive forward its development. It is a model used in a number of other healthcare professions and would reinforce the CPD system's approach to practitioner development.

The management capability of the Institute will be pivotal to its success. It must be headed by a experienced and strategic Director, with extensive qualifications within the pharmacy field. He/she must have a clear vision for development of the profession, an understanding of its characteristics and component parts and comprehensive knowledge of CPD and its relationship to patient outcomes.

The Director would be supported by the representative Management Board referenced above. It is envisaged that this Board would be kept reasonably small and focused to assist in executive decision making. It should include nominees from the IPU and HPAI and an appropriate representative mechanism from industry to ensure representation from community, hospital and industry settings; a representative from academia (via a nominee from the three pharmacy schools); a representative from PSI; and a representative from the HSE. The members of the Board should be nominated on the basis of defined competencies that would include the ability to represent their respective interests, think strategically about the development of the pharmacy profession and understand CPD and the needs from the system. The appointment to the Board of a representative from the Pharmaceutical Society of Northern Ireland to introduce an all-island dynamic is also worthy of consideration. It is important that a consistent approach to delivery and development of pharmacy services is in place in both the Republic of Ireland and Northern Ireland and the presence of such a representative will help to develop synergies between the two systems.

To frame the activities of the Institute, a Strategic Plan should be produced over an initial five year period, setting out the objectives of the Institute and key targets and milestones for delivery. Annual business and action plans would then be produced to detail activities and budgets each year. Both plans would be produced by the Director in conjunction with the Management Board and signed off by the Board prior to implementation.

The Institute would accredit providers and activities which the pharmacist could then access. The Institute would however acknowledge that not all CPD involves formal accredited programmes and would also recognise engagement in other activities relevant to professional development for an individual pharmacist. Broadly defining what is relevant in this regard for pharmacists in different settings will be an important early objective.

The Institute must also monitor engagement in CPD across the profession and it would do this by managing the practice review and CPD portfolio processes which underpin the system. This is a critical component of the model as it is the means by which competency in practice standards will be assessed on an ongoing basis. The Institute would be expected to take a strong leadership role in establishing CPD portfolio and practice review systems, securing the levels of peer engagement to ensure effectiveness of this latter approach. It would also deploy the right to review individual CPD portfolios as an important control. Management of the assessment process by the Institute also allows the developing competency of the profession to be monitored over time – in effect benchmarking its performance as the CPD system becomes established and continues to evolve. This is a theme to which we return in Chapter 12 of this report.

Supporting implementation of a CPD system at local level must also be recognised in the management of the system. We discuss the importance of establishing local support infrastructure and incubator cells or units to facilitate implementation and the Institute could play an important coordination role in this respect.

The advantage of such an Institute model is that the Institute itself should not be resource intensive and is therefore relatively easy to implement. It can serve initially as a virtual institute, drawing on key expertise and building on existing infrastructure. Discussions with stakeholders suggest that establishing a distinct Institute at a very early stage in the implementation process will send an important message to the profession and focus action in establishment of the wider CPD system. There is a strong rationale for establishing an Institute in this way as a driver of implementation of the CPD system as a precursor to its role in managing delivery of the system once established.

The principle of keeping the Institute as a strategic, managing, accrediting and commissioning leadership body, and in so doing minimising the need for substantial resources, allows it to build on other structures as it becomes established. In the current fiscal environment, creating an additional resource-intensive structure is unlikely to gain any support. However if an organisation could be found within which the Institute would comfortably sit, then this could present the ideal solution for generating a distinct and focused Institution approach without formally establishing a completely new body.

The work of the ICCPE has been a notable asset to the profession in recent years and it is important that this work is built upon in the delivery of the Institute. It would be hoped that the expertise and resources that currently exists in the ICCPE could be deployed via the Institute in the future. We also note the outcome of the Report on Continuing Pharmaceutical Education[91] by the ICCPE which identified potential for the organisation in taking on a more in-depth role in supporting CPD for the pharmacy profession in Ireland. The report commissioned by the ICCPE also envisions the ICCPE remit being extended from community pharmacists "to all other pharmacists providing or intending to provide services in the Irish healthcare system, including hospital pharmacists, pre-registration graduates and also to pharmaceutical assistants[92] and technicians."

However, while the work of ICCPE has been positively received by stakeholders, the findings from the consultation process suggested a need for an entity to manage and drive CPD that was perceived as more independent and that would help communicate the new approach to CPD within pharmacy in Ireland. Indeed to find a suitable support structure to deliver an effective CPD system, a number of key characteristics would be important:

- independent of any of the stakeholders directly involved in the pharmacy profession
- possession of the infrastructure to support this type of function (in terms of IT systems, processes, etc)
- experience and expertise of managing effective CPD systems
- access to an interdisciplinary range of activities
- ability to accredit specialisations, confer fellowships and honorary fellowships
- ability to draw upon expertise of a horizontal nature such as finance, HR, logistical support, expertise in adult education
- potential to act as a vehicle for research delivery and will bring all schools together in a collaborative forum.

If a suitable support structure can be found that displays these types of characteristics, the option of basing the Institute within such a structure should be further examined[93].

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[91] Pharmacy: A Report on Continuing Pharmaceutical Education in Ireland, Irish Centre for Continuing Pharmaceutical Education, 2008

[92] It should also be noted that the ICCPE currently provides its programme of CE activities to pharmaceutical assistants

[93] The IPU have singularly stated that they believe "that the current proposal on the table is an unnecessary waste of scarce resources. Existing resources with established funding such as the ICCPE should be deployed. It is unnecessary to establish a new body to accredit CPD, as this can be carried out by the PSI and the ICCPE is already well positioned to deliver CE and support engagement with CPD". The intention of this proposal is not to duplicate resources in any implementation but to acknowledge that the expanded brief of the Institute requires the support of the entire profession and a governance structure that represents the entire profession. There was no consensus on the IPU viewpoint and it is included here for completeness. The authors of this report recognise this point but do not believe that the deployment of CPD through the Institute model would duplicate resources.

10 Costs and funding of the CPD system

With proposals for governance, management and provision structures and systems established, it is important to consider how these will be progressed alongside the other components of the CPD model. The first challenge in this regard is to consider the broad cost and funding implications with regard to the proposals. This Chapter focuses upon providing an indication of costs and how these might be funded. This can help to inform a full costing exercise and agreement of funding responsibilities as implementation moves forward.

10.1 Indicative costing of proposals

We set out a potential approach to governance and management via the development of an Institute model in the previous chapter. In comparison with other possible options, we believe that this model would yield the greatest long-term benefits for patient safety and patient outcomes. It is acknowledged that the establishment of the Institute model and development of a CPD system in line with the proposals in this report will have initial cost implications. The full extent of these will only become clear as the detailed specifications of the model are agreed moving forward. However full implementation will only be feasible if the costs to be incurred are fully articulated and the clear business case for this investment is established.

The first step in implementation of this proposed approach must be a full and robust costing exercise and analysis of the benefits that will be generated over time as a result of the CPD system. In undertaking our analysis, we have attempted to gather an indication of the types of costs that would be incurred in the development and the ongoing delivery of a CPD system. This is complex, as other geographies exhibit significant differences in terms of scale of the profession, approach to governance and management and extent to which the pharmacist is expected to pay for CPD activities. The latter variable makes transferability of costings particularly problematic, as within most CPD systems there exist varying pricing policies for different activities which range from full to zero recovery from the professionals. Identifying the exact costings of the components of other CPD systems for pharmacy systems is also highly difficult to source.

In trying to develop a high level understanding of the costs that would be expected to be incurred in development, roll-out and delivery of the system, we have therefore chosen to build up a broad picture based on the key principles:

- That ***development costs will be required*** to effectively establish a CPD model and must be taken into account alongside delivery costs.

- That the scale of these development ***costs*** is ***minimised by working in partnership*** with relevant organisations and ***building on existing structures and processes*** (e.g. by utilising existing communication mechanisms and representative organisations, sharing and building upon existing IT systems and resources, using local infrastructure already in place, etc)
- That ongoing delivery costs are based on an acknowledgement that ***existing provision*** (of CE by funding of ICCPE and other non-funded interventions) ***needs to be extended to ensure that a portfolio of CPD activities exists*** that meets the needs of those at superintendent, supervisory and general levels and working in hospital, community, industry and academic settings.
- That the current financial environment means that balancing funding for development costs and ongoing delivery costs may mean a ***phased introduction of delivery***.

Figure 10.1 uses these principles to broadly identify outline costs for each of the cost components typical in establishment and delivery of a CPD system.

Figure 10.1: Outline Cost Estimates for Development and Ongoing Delivery of an Irish CPD System

Development Costs		**Ongoing Delivery Costs**	
Support infrastructure	€300,000	Resourcing of Institute	€150,000
Communication strategy	€100,000	Delivery of CPD activities	€1,000,000
Testing and validating CPD system	€200,000	CPD portfolio infrastructure	€100,000
Establishing CPD infrastructure	€300,000	Practice Review Process	€500,000
		Remedial interventions	€50,000
INDICATIVE TOTAL	***€900,000***	***INDICATIVE TOTAL***	***€1.8mn***

This analysis can only serve as an initial overview of the costs that might be involved in the CPD system in order to provide a platform for discussion and agreement on funding and other support for this system. A full and detailed costing exercise will have to be undertaken as part of the implementation phase, once detailed specifications are established for all of the model components, complimentary resources to assist development and delivery are identified and potential funding sources further investigated.

10.2 The business case for investment

Alongside full analysis of costs of this kind, the benefits from this investment must be made clear to justify any funding. Essentially the main outcomes that should be generated from an effective CPD system for pharmacists in Ireland involve:

- Generating ***efficiencies in service delivery*** by the profession (e.g. by sharing good practice with peers on efficient delivery of community pharmacy services; by developing common approaches to patient treatment via special interest groups for hospital pharmacists)

- Improving the ***effectiveness of delivery of pharmacy services*** in order to improve patient outcomes (e.g. by working closer with other healthcare professions at community level to provide holistic support to meet patient needs; by improving knowledge of particular drugs and treatment via education and peer networking and offering more tailored responses to patients)
- Developing and demonstrating competencies that will allow the ***profession's role in wider healthcare provision to evolve*** and result in more efficient and effective delivery of patient outcomes (e.g. by taking on new responsibilities for prescribing, vaccination services, etc that provide more localised and cost effective responses to meeting patient needs).

All of these impacts will ultimately lead to a lowering in the cost of healthcare expenditure due to improved patient outcomes or delivery of existing patient outcomes with fewer resources. This establishes a return on the investment in CPD.

There is evidence from international research that positive impacts have resulted from the establishment of CPD systems, although measuring these impacts remains problematic. Foppe van Mill et al (2004)[94] found that FIP's CE and CPD activities had established "agents of change" that have had an impact on the profession. Although CPD systems are relatively young, thus limiting the extent to which ex-post evaluation has taken place, there is evidence that activities related to CPD such as collegiate[95] working and peer networking via professional meetings[96] are more effective in influencing practice than traditional CE activities. This evidence must be used to reinforce the case for investment. In addition to providing evidence of success from other equivalent systems, it is critical to measure outcomes as they arise in Ireland from now on to demonstrate return on investment and this will be further considered in Chapter 10.

A further important consideration in building the business case for expenditure on a CPD model is extent of ***deadweight*** in its implementation or non-implementation. Deadweight occurs if there is evidence that the above outcomes would occur in any event without the intervention of a CPD system. Without such a system in Ireland however, the realisation of these benefits could be expected to be much more fragmented if occurring at all.

[94] Changing a profession, influencing community pharmacy, J.W. Foppe van Mil, Bente Frokjaer, Dick F.J. Tromp, Pharm World Sci 2004; 26: 129–132, January 2004

[95] The role of collegial interaction in Continuing Professional Development, Anna R. Gagliardi, Frances C. Wright, Michael A.B. Anderson, Dave Davis. Journal of Continuing Education in the Health Professions, 27(4):214-219, 2007

[96] Use and effectiveness of pharmacy continuing education materials, Vittorio Maio, Dea Belazi, Neil I. Goldfarb, Amy L. Phillips and Albert G. Crawford. American Journal of Health-System Pharmacy, August 2003

More pertinent in the deadweight question is what would happen to the profession and protection of patient safety if no CPD system is introduced. We have noted in our analysis that a proportion of the profession do not currently engage with CE activities currently available. This has led to some concern that some pharmacists may be failing to keep their skills and competencies up-to-date, patient safety is put at risk while inconsistent levels of service may become apparent across the country. It is not clear to what extent this is the case, but even a failure to demonstrate that competency is being maintained across the entire profession makes it difficult for pharmacy to take a prominent role in a rapidly changing healthcare environment which requires health professions to take on new roles and responsibilities. An effective CPD system performs this function, and without this intervention there could be a significant risk of an increasingly isolated profession with inconsistencies in practice and limited linkages with other healthcare professions to improve patient outcomes. This risk must form an integral part of the business case for investment, particularly as healthcare and the role of pharmacy continues to evolve.

A further case for investment lies in the support for the pharmaceutical manufacturing industry that a strong pharmacy professional can yield. This industry is a significant economic asset for Ireland and has remained robust through the current recession. There is already a base of pharmacists working in this industry although it is acknowledged that there is potential for further growth in this area. An effective CPD system can help build the expertise to allow this potential to be fully maximised. Furthermore a strong pharmaceutical manufacturing industry can only be enhanced by a strong pharmacy profession and a CPD system plays a role in demonstrating the expertise of the profession. If competency is unclear however, this could also have an adverse effect on the wider pharmaceutical industry and this is something which investment in CPD can guard against.

10.3 Establishment of funding responsibility

Once a strong business case for investment in establishment of the CPD system has been put together, the next challenge is securing the sources of funding required. HSE support will be necessary to help meet the development and delivery costs but this will only be forthcoming with a clear rationale for funding in terms of improved patient outcomes and long-term savings in expenditure. It will also be dependent on maximising contributions from other key sources of funding, including the regulator, employers in the sector and the profession itself.

At this point it is worth revisiting the approach to funding across the pharmacy CPD models reviewed. Figure 10.2 provides an overview of the different sources of funding for CE and CPD across the geographies. In the Irish case, the ICCPE continuing education activities are currently funded by the Department of Health and Children. Across the other models, there is a consistent expectation that pharmacists meet at least some of the costs of CPD or CE activities. This can be via a participation fee for each activity or as part of a membership fee provided to a professional body. Government supports CPD and CE activities across most geographies but there is a strong focus on finance only for those interventions that specifically relate to wider healthcare objectives. Where the regulating body becomes involved in funding CPD, this tends to be concentrated on support for the tools, systems and administration that will facilitate engagement and allow the pharmacist to demonstrate the competency that will allow him/her to remain on the Register.

Figure 10.2: Approach to Funding of CPD Across Geographies

	Professional (at participation)	Professional (via membership fees)	Government	Regulator	Industry
Ireland (CE)	◑	◑	●		
Portugal	●	◑			
Great Britain		●	●		
Northern Ireland		●	●	●	
New Zealand		●	◑	◑	
Canada - BC	◑		◑	●	
Canada - Ontario	◑		◑	●	
Australia	◑	●	●		
United States (CE)	●	◑			
Netherlands (CE)	◑	●			
Finland	●		●		●

Taking our analysis of other models and understanding of the Irish context, we are able to develop a suggested indicative funding model for further discussion. This model is based on a high level estimate of developmental and ongoing operational costs of a CPD system. It takes account of the goals of particular stakeholders and the contributions that could be expected in line with these goals. Key features include:

- ***Public funding*** (via the HSE) to help meet the ***initial development costs*** for the system (in implementation areas such as establishing support infrastructure, communicating with the profession, establishing and testing the CPD infrastructure which are further discussed below). Over time the HSE's role will be ***funding activities that relate directly*** to achieving their objectives in delivery of the ***healthcare system***, reducing its contribution to CPD system costs. This assistance for delivery of relevant CPD activities is based on the current level of resources deployed for ICCPE provision.

- PSI offering an ongoing contribution to ***costs*** of the tools and systems to facilitate engagement in CPD as the ***regulatory body*** requiring a model that can demonstrate the ***ensuring of competency***.

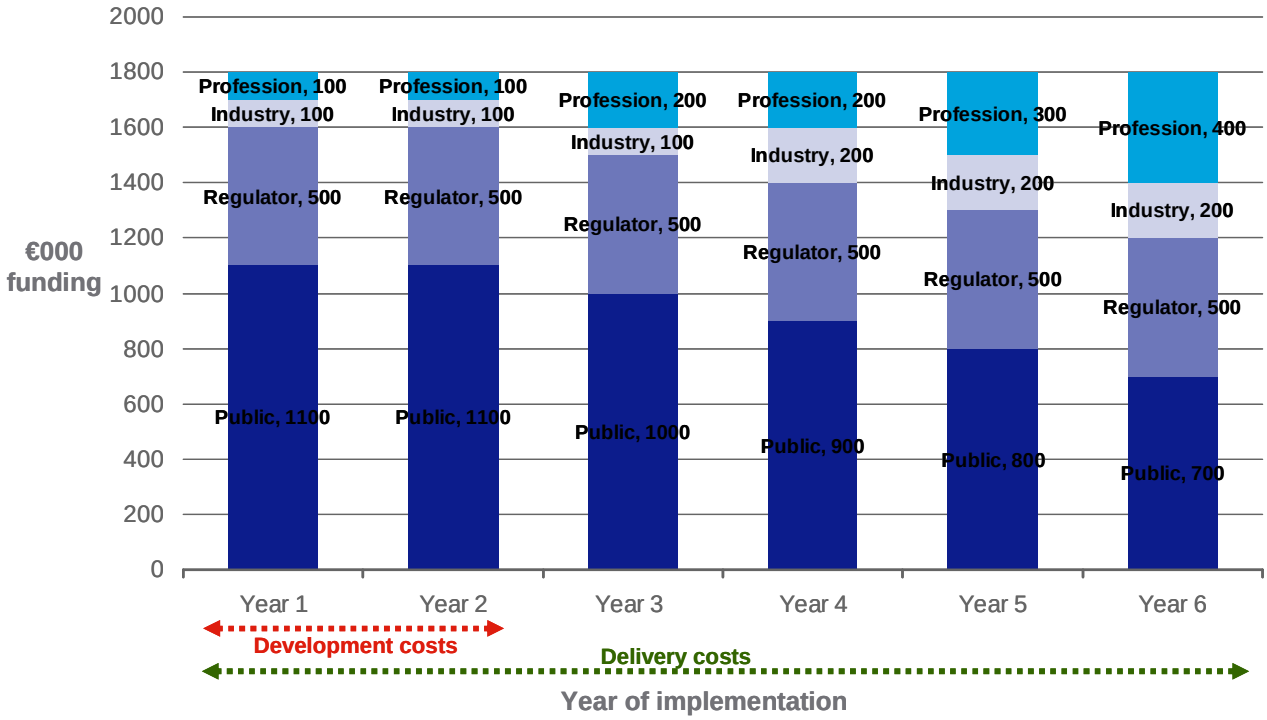
- More formal recognition of existing resources deployed by the ***profession*** in CPD related activities while also acknowledgement that in the ***longer-term the profession should move towards greater self-sufficiency*** in its approach to professional development.

In addition to these core funding principles, there is worth in considering the potential of industry as a funding source for CPD activities if an approach can be found which supports efforts to focus more on general development led activities in preference to commercially focused initiatives. This might involve considering how industry-delivered education and training is accredited within the CPD system and how the role of industry in this regard is recognised, in accordance with the relevant laws and Code of Practice. From consideration of other models, there would seem to be scope for some industry contribution to support of professional development. The applicability of the industry funding model in Finland, where industry contributions are pooled to remove bias in the deployment of resources is worthy of further consideration. There is a need for a strong commercial focus in this regard, seeking sponsorship and opportunities for partnership working with relevant corporations, in order to ensure the sustainability of the institute over time. However such funding must be non-conditional, deployed in the manner directed by the independent CPD management body and compliant with all state regulations.

These funding relationships must be agreed and formalised as the full details of the CPD model are worked out. However they are based on the fundamental principles of public investment only where there is a clear return on investment from improved patient outcomes, regulatory body investment to ensure competency of the Register can be demonstrated and increased self-sufficiency by the profession in the CPD system over time to reflect the benefits to the professional.

The indicative funding model for the CPD system which reflects these principles and formalises these relationships is shown in Figure 10.3. This estimates an annual budget of €1.8 million as set out earlier in Figure 10.1, with investment in the initial years supporting development in addition to delivery costs. The budget is assumed to remain constant in real terms and should be adjusted year-on-year in line with the Consumer Price Index. It assumes a contribution from the pharmacy profession which will increase over time to demonstrate greater self-sufficiency and recognise the value obtained from the system. It should be noted that pharmacists already contribute to the costs of CE in this way, with an annual €50 fee applied to community pharmacists to access the learning resources of the ICCPE. More generally, pharmacists across all settings often pay fees to access educational or development activities and may also receive some funding from their employer to support this.

Figure 10.3: Indicative Funding Model for the New CPD System for Pharmacists



11 Implementation of the CPD system

In this chapter we consider an appropriate approach to roll-out and implementation of the Irish CPD system for pharmacists. We firstly provide an overview of the critical success factors to underpin effective implementation. We then discuss the key aspects of implementation, highlighting the issues that must be addressed in each case.

11.1 Critical success factors in implementing a CPD system

In the previous chapters we have discussed the vision, key principles approaches and characteristics on which a new CPD model for pharmacists should be based. We have also provided some initial indicative analysis on costs and funding for further discussion. The success of the CPD system will also depend on the way in which it is rolled out and implemented within Ireland. While the merits of CPD are widely acknowledged, implementation poses a number of complex challenges[97]. A number of lessons can be learned from international experience of implementing CPD systems and we can build on this experience to define an appropriate approach for roll-out of the Irish system. A good starting point is the recommended approach by the International Pharmaceutical Federation (FIP) for the implementation of CPD. FIP recommends[98] that national pharmaceutical associations in co-operation, where appropriate, with schools and faculties of pharmacy and other education providers coordinate a process involving:

- Establishment of national learning needs;
- Motivation of pharmacists by demonstrating how individual competence can be improved and thus the advantages of participation in CPD;
- Raising awareness of appropriate frameworks for personal development plans and recording systems;
- Providing opportunities for CPD by facilitating the provision of a wide range of CE programmes in a variety of formats.
- Ensuring that opportunities are available for individual pharmacists to learn how to draw up SMART plans (Specific, Measurable, Achievable, Realistic and Timed) for a personalised programme of CPD;

[97] 'Continuing professional development in pharmacy', Michael J. Rouse, American Journal of Health-System Pharmacy, October 2004

[98] Statement of Professional Standards for Continuing Professional Development, FIP.

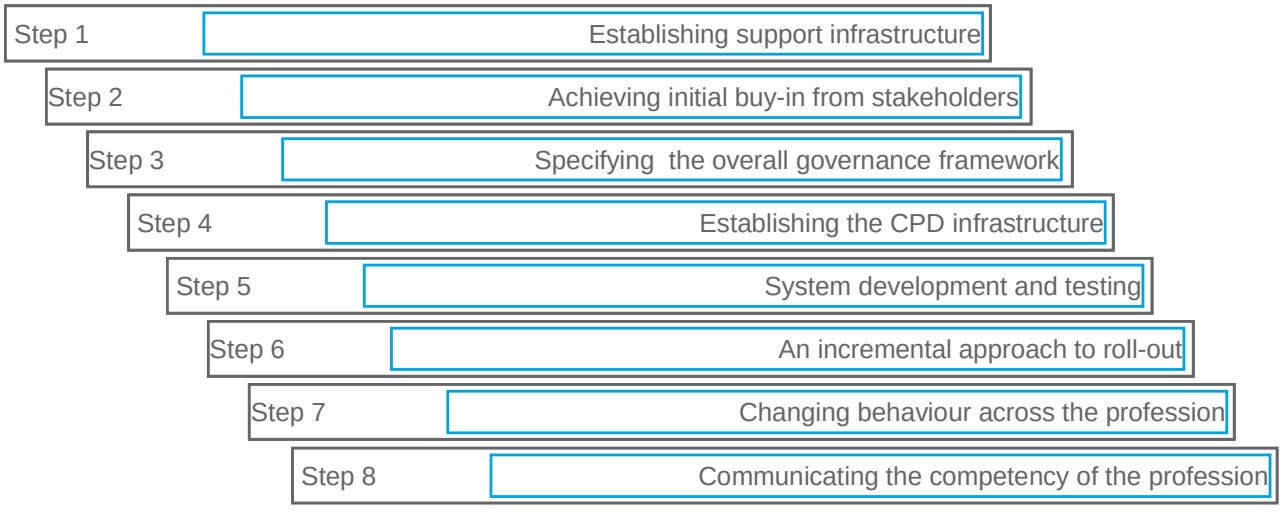
- Establishing mechanisms for individual evaluations including questionnaires, checklists, rating scales and self-assessment tests, which are effective and are easy to apply for all types of CPD activity;
- Recommending standards for CE providers and establishing an effective accreditation system.
- Providing the knowledge and shared resources for CE programmes, which are based on pharmacists' competence to practise;
- Establishing quality assurance systems for CPD activities against the learning objectives.

Alongside these FIP components, there are particular issues that will have to be considered in an Irish context that will have to be addressed to ensure success for the CPD system. These are to some extent reflected in the core principles defined in Section 8.2 but principally involve:

- Full costing of the proposed approach with a clear business case for investment by potential funders
- Clear communication of the purpose, requirements and benefits of the CPD system
- Support for the profession in understanding and responding to CPD requirements
- Buy in and engagement by the entire profession
- Engagement of peers in the development and delivery of the CPD model
- An incremental approach to roll-out
- Clarity on the competencies that the CPD system is trying to assure

These factors are reflected in the implementation themes shown in Figure 11.1. Each of these themes is discussed in further detail from section 11.2 onwards. These themes should guide the work of the implementation group that will be established by PSI to ensure that an effective CPD system can develop.

Figure 11.1: Key Implementation Steps for a New CPD System



11.2 Establishing support infrastructure

This report has highlighted the differing characteristics or pharmacists in different settings, both in terms of whether they work in industry, hospitals, the community or academia and in urban or rural, and often isolated environments. Establishing a culture of support is proposed as a core principle of the system and tailored support is critical in helping pharmacists, particularly those without a readily available peer network, in a number of areas including:

- understanding why the CPD system is being introduced
- what it means for them as pharmacists
- how it will help improve practice and
- how they will be supported on an ongoing basis to engage with CPD while accommodating the business and work pressures that they face.

The establishment of incubator units or cell structures which would bring pharmacists together as peers could be an important component of developing the system. These units should involve a cross-section of representatives from the profession including the different settings. This would help to shape the details of the new system, iron out any issues before full roll-out and build buy-in among the hardest to reach groups. It would ensure that they have access to the appropriate technology to access all the tools underpinning the system and help develop the skills and knowledge required to use these tools effectively. It would build confidence in engaging with peers and encourage use of mechanisms such as an online forum to continue this interaction remotely. As the system develops they would also be a key mechanism in dissemination of information and sharing good practice and consideration should be given to maintaining the structures as an ongoing support resource after full roll-out of the system.

A further local support measure worthy of consideration is the introduction of a peer mentoring or buddying system. Facilitating interaction of this kind can be important in sharing good practice, discussing issues and concerns in relation to the new CPD system and using peer shadowing by this buddy or mentor to identify areas where the pharmacist might engage in CPD.

11.3 Achieving initial buy-in from stakeholders

A key aspect of the effective roll-out of a CPD system is the ability to get buy-in and commitment from the individuals across the profession that will be expected to engage in CPD activities. While a mandatory system can to some extent enforce engagement in a system, it will only prove successful in the long-run if the profession as a whole can be convinced of a system's benefits. A primary objective in the implementation of a CPD system must therefore be securing ownership by pharmacists working across all of the professional settings: community, hospital, industry and academia. Establishing the support infrastructure noted above will be important but critical aspects of the process will include:

- Establishing a fully inclusive and meaningful consultation process that allows everyone to comment on the provisional recommendations for a new CPD system;

- Seeking full sign-off on core principles and professional competencies by all stakeholders under an overall commitment to improved patient safety

An important aspect of securing buy-in is recognition of the existing continuing education resources with which many pharmacists currently engage. A successful transition from a voluntary CE system to a CPD approach will mean effective communication of exactly what CPD involves and how this builds upon the current CE activities accessed. Emphasising that such CE activities will continue to be recognised as important in CPD engagement will be critical, as will demonstrating how CPD aims to take learning like this and ensure that it influences pharmacy practice. The work undertaken by the ICCPE in looking at the transition to a CPD system is useful in this regard and this should be built upon in the approach to securing buy-in to the system by the profession.

Finally, buy-in to initiatives across a profession like pharmacy has traditionally been constrained by the geographical spread of pharmacists and the fact that many operate in an isolated environment with little opportunity to engage with peers. Technology provides a mechanism to break down these barriers and an aspect of building buy-in should include the building and support of a virtual community of pharmacists. This would allow issues to be raised, good practice highlighted, questions resolved and ideas for development of CPD discussed. It could perhaps form part of a wider e-learning platform where some learning could be delivered online. A resource of this kind should make it easier for the previously harder to reach pharmacists to engage in the system and with their peers.

11.4 Specifying the overall governance framework

A key aspect of implementation is clarifying structures to be put in place for governance, management and provision of CPD. We have proposed approaches and overall roles within this report that should form the basis for an overall governance framework. However detailed specifications will have to be agreed in each case as funding sources are confirmed and the model is further articulated. Alongside definition of detailed specifications, service level agreements may have to be put in place and contractual issues addressed in order to ensure that there is complete clarity in what is expected from each stakeholder organisation.

PSI has an already defined role in regulating the registration of pharmacists and a legislative obligation to oversee introduction of a mandatory system of CPD, with the power to strike off those that fail to engage in CPD and meet their defined competency standards. As the Institute is established, its role in managing and overseeing the CPD system would be expected to encompass:

- Responsibility for shaping, influencing and ultimately accrediting the CPD activities
- Responsibility for supporting pharmacists engagement in CPD activities
- Responsibility for assessing practice standards of pharmacists

The Institute also provides the mechanism by which representation is provided across the profession, with a management board comprising a cross-section of relevant representatives. As noted in Chapter 8, the Institute is not envisaged as requiring significant resources to operate and as such an important early step should be to establish this Institute as a formal entity. A key aim of the implementation group should be to put in place the conditions to allow an Institute to be launched as manager and driver of the overall CPD system. An important first step will be establishing the nature of the management board that will help to shape its direction, drawing on a cross-section of representatives with an interest in the development of the profession.

The delivery role in the framework will be relatively fluid, consisting of a range of different providers that have been accredited by the Institute. This will help to ensure that existing CPD activities continue to be recognised and that the differing needs of the profession are met by appropriate bodies. Providers may range from academic institutions (e.g. the three pharmacy schools) to employers (e.g. HSE or industry training programmes) and profession led initiatives (e.g. ICCPE continuing education, activities supported by the IPU or HPAI).

11.5 Establishing the CPD infrastructure

For a CPD system to work effectively it must be underpinned by appropriate infrastructure that supports personalised development pathways, facilitates self-reflection by the pharmacist, provides for assessment of competency and remedial action and allows multiple providers to become engaged in delivery. It is envisaged that the scope of infrastructure required would incorporate:

- A system based on maintaining a portfolio of CPD activity that includes reflection on the outcomes of this activity on practice will require particular infrastructure to be put in place, with interactive, online resources particularly suited for this purpose.
- Creation of a blended model maximising the use of e-learning but still maintaining the paper option for those not currently IT literate (or able to access appropriate technology). This might involve the development of a virtual learning environment (VLE) as a delivery tool for e-learning. A commitment to blended learning is in line with the vision for CPD of a flexible and user-friendly system.
- Infrastructure needed for a robust practice review component with peer involvement, including the exact nature of this process and resources required (e.g. facilities, assessment tools, peer training, staff involvement)
- Remedial interventions for those pharmacists experiencing issues with regard to meeting defined competency levels.
- Clear processes and systems will also have to be put in place to underpin the accreditation process (e.g. the application process, selection criteria, assessment process, awarding structure, etc).

- IT infrastructure to support access to online portfolios, e-learning modules, peer forum and other web-based tools and information. Alongside ensuring that every pharmacist has the required IT infrastructure, equipping individuals with the knowledge and skills to use the CPD tools is equally critical, and the support infrastructure discussed above will play a critical role here.

A scoping exercise to determine the exact nature of infrastructure required in this regard will have to be undertaken as part of the implementation process. This will provide a platform for development of the tools and mechanisms needed to allow the CPD system to operate effectively.

11.6 System development and testing

With the specifications defined for the CPD infrastructure required and the associated systems and processes, it is necessary that these are fully tested with a cross-section of the profession prior to roll-out. The key weakness of a voluntary CE system has been the lack of engagement by a 'hard to reach' cohort of the profession and it is essential that any new developments are fully tested with this group in order to determine if engagement by this group can be obtained. An intensive piloting and testing phase must therefore be undertaken to ensure that a practical and efficient system is put in place. This would be expected to consider questions including:

- Is sufficient support available to help the pharmacist engage with the CPD system?
- What is the purpose of the CPD system and how should this be made clear to the pharmacist?
- Are the tools easy to use and is training available to support their use?
- Is technical support available for those experiencing difficulty with the tools?
- Is there a clear contact point for pharmacists with regard to matters relating to CPD?
- How is peer interaction being supported?

The incubator units discussed in section 10.2 above could provide an ideal platform for deploying a sample of pharmacists from different settings to pilot the different components of the model and identify further support needs. Whether it is piloting the interest in and feasibility of activities like journal clubs or testing the ability to engage in a VLE to access e-learning modules for pharmacists, the incubator units or cell structures could test relevance and applicability across different cohorts in the profession. The components can then be further shaped, revised and retested in further iterations before full roll-out.

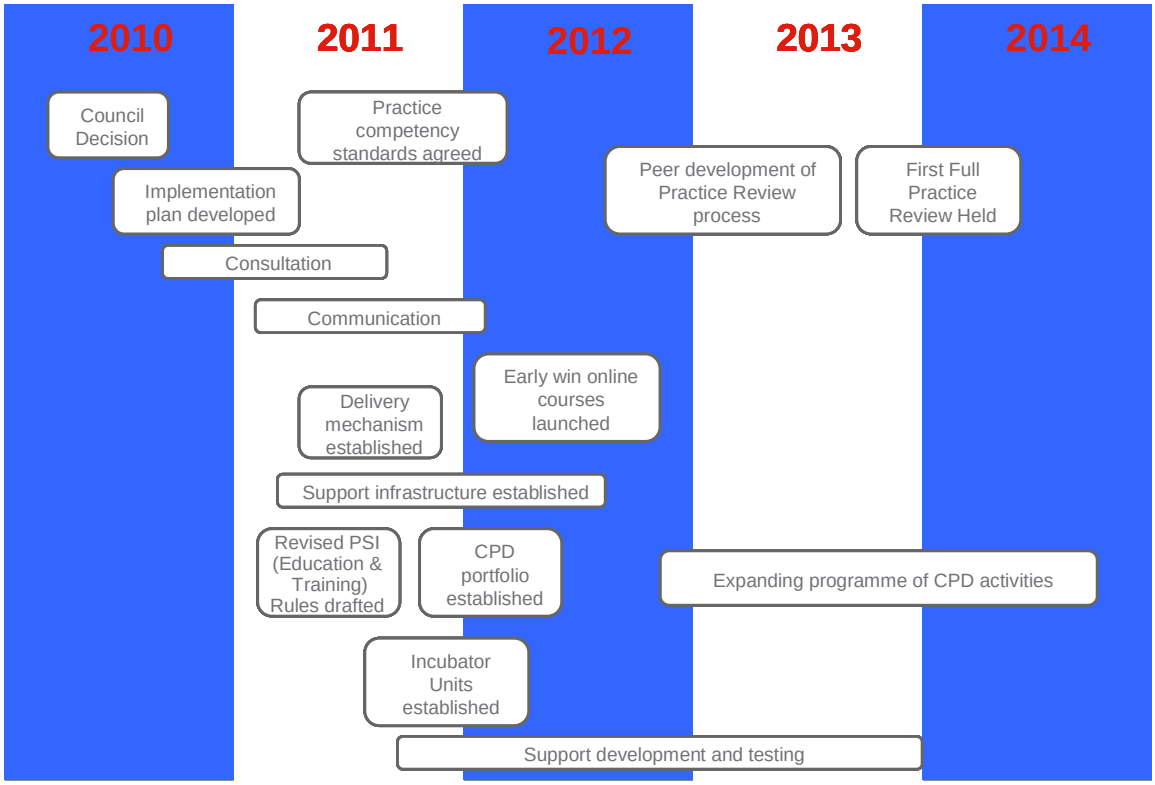
11.7 An incremental approach to roll-out

The introduction of a CPD system will require quite radical change across a profession used to only voluntary engagement in continuing education activities. One of the critical lessons from considering international models of CPD has been the need to avoid over-ambitious switchovers to new systems that require significant changes in behaviour. Full roll-out of the desired CPD system with comprehensive engagement by the profession may take up to 5-6 years to achieve. A transitional approach to introduction of new tools, the roll-out of standards, the requirements on the individual pharmacist and the accreditation and assessment processes will be essential. Successful establishment of a CPD system will require a series of small incremental steps before full roll-out, ensuring continued buy-in and ownership of the profession along this journey. One of the first steps must be development of the CPD portfolio system as a means that will help pharmacists to record and reflect on CPD activities. As we have noted earlier in this report CPD can build upon much of the activity in which pharmacy is already engaging and early establishment of the portfolio to demonstrate this to each individual would be a notable step in securing further buy-in.

A further key component in the incremental approach to roll-out should be the attainment of ‘early wins’ from the CPD system where participation is made easy from the outset and the benefits of a particular activity are clear to the profession. This could be achieved by launching a number of useful and accredited online courses in the early stages of development, available on the Institute’s website (which would also provide an early indication of the added value of the Institute). There might be ‘off the shelf’ e-learning modules available elsewhere that could be made accessible to Irish pharmacists for the first time in this way. By providing previously unavailable flexible learning opportunities as a taster of what CPD might involve, this should help achieve buy-in and provide a foundation for further and more extensive engagement in the CPD system.

An example of how an incremental approach to roll-out might be built up is illustrated in the diagram in Figure 11.2.

Figure 11.2: Example of an Incremental Approach to Roll-Out



11.8 Changing behaviour across the profession

Changing behaviour across the profession is central to a successful transition. It will require a gradual introduction to the concept of CPD and illustration of how it builds on much of what many individual pharmacists are already doing. Promotional and educational campaigns will be important with the endorsement of representative bodies a potential key asset in this process. These should strongly emphasise the overriding objective of the system in improving patient safety. They should also highlight the easily accessible support that is available to help embed the new system and the tools that accompany it. Any problems that arise should be addressed quickly and with the focus maintained on a simple accessible system – being responsive to suggestions and criticism will be a key attribute that will encourage buy-in across the profession.

Supporting peer engagement and creating peer networks will be an important mechanism in sharing experiences, issues and ideas. The establishment of a peer buddying or mentoring system to provide an additional support for the individual pharmacist is an idea worthy of further consideration. It may offer a peer engagement outlet for pharmacists in isolated locations who feel unable to engage in peer networks.

11.9 Communicating the competency of the profession

Communicating the competency of the profession externally presents a final but important challenge. Part of the vision for the establishment of the CPD system is to demonstrate the current competency of the profession and the way in which this is developing to the wider healthcare sector. The pharmacy profession in Ireland is evolving at a time of significant change across healthcare and it is important that implementation of the CPD system is also used to communicate the ability of the profession to respond to, shape and drive the wider health policy agenda in Ireland.

Highlighting the nature of the system itself and the overriding focus of patient safety will be an important external message. As outcomes emerge from the process, a theme further discussed in Chapter 10, these should be communicated outside the profession to highlight the positive role pharmacy plays in healthcare provision. An inter-disciplinary focus in the nature of CPD activities is also an important communication mechanism that should not be overlooked. If the system can support greater interaction and closer working with other healthcare professionals it will demonstrate competency and excellence across healthcare delivery and help its role to evolve in line with the needs of patients at community level.

12 The new CPD system and its role in improving patient safety

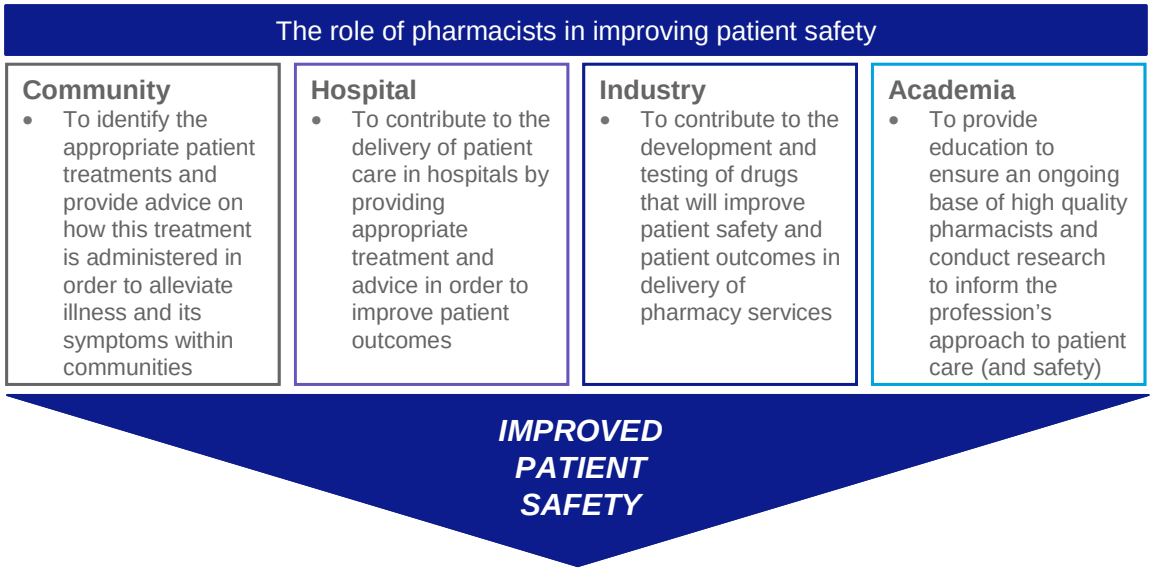
The establishment of a new CPD system, underpinned by an effective approach to standards, accreditation and assessment and a clear governance structure, provides an opportunity for the profession to develop its role in improving patient safety. Tracking the progress made as we move forward should be a key objective, and if we can find a means to benchmark the contribution of pharmacy to patient safety at the outset of the CPD model, we can then consider its relationship with improved competencies and patient outcomes. We conclude our report by considering how we might monitor the role of the new CPD system in this regard as we move forward.

12.1 The role of pharmacy in improving patient safety

The establishment of a new system of CPD for pharmacy provides a significant opportunity to examine the profession's role in ensuring patient safety and generating improved patient outcomes. Our analysis has found that the system must be underpinned by an overarching focus on such patient outcomes and an ability to identify tangible measures of success in this regard would be a considerable asset. It would help individual pharmacists to understand the importance of CPD to maintenance of competency and practitioner development and relate this to the ultimate impacts on pharmacy practice. It would also serve as a key tool in demonstrating the competency and value of the pharmacist outside of the profession, a critical factor in a rapidly changing healthcare environment where professional roles are continually evolving.

The establishment of such a system that can track the impact of CPD in supporting and developing the role of the pharmacist in improving patient safety is complex. The first step involves setting out a high level understanding of how patient outcomes are delivered by pharmacists in different settings. The pharmacy profession possesses significant expertise and experience and offers a clear contribution to securing successful patient outcomes and ensuring patient safety. Regardless of the setting in which pharmacists practise, they play a clear role in meeting these overriding healthcare objectives, and Figure 12.1 provides a simple overview in this regard.

Figure 12.1: The Role of Pharmacists in Improving Patient Safety



12.2 Inter-dependency with other healthcare professions

While the role of pharmacy in improving patient safety can be mapped in simple terms, securing patient outcomes has often a high degree of inter-dependency with the work other professions. In reviewing international CPD models and recommending appropriate means and methods for a system for pharmacists in Ireland, we have noted the need for a strong focus on inter-disciplinary working and interaction.

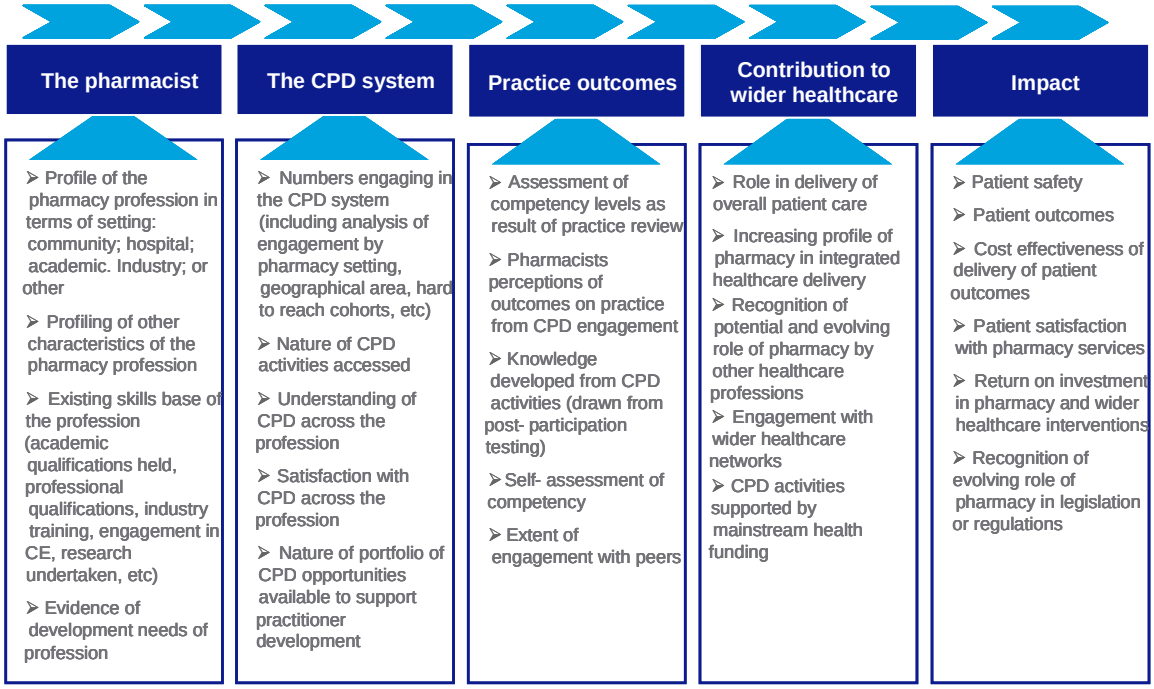
Winslade et al (2007) examined how practice performance might be measured and identified the influence that the wider healthcare system can have on the impacts that are generated from practice. It noted how a key motivating factor within the pharmacy profession must be the perception of its performance within the wider healthcare system and the support by this system of pharmacist provision of services. Practice performance can enact change within this healthcare system in terms of changing legislation and regulations, reimbursement, access to information and attaining increased or changed responsibilities for the profession. Such change can then lead to lower costs in healthcare provision and improved patient outcomes.

A joined-up system of CPD for pharmacists that takes account of wider healthcare objectives is essential and the Education, Training and Research: Principles and Recommendations report produced by the HSE should be a key reference point in linking CPD activities to overall patient outcomes. This report envisages a system for education and training that mirrors much of the approach of the Irish system in this report, with educational input extending "from the first day as an undergraduate student to the last day of professional service and should incorporate all healthcare professions encompassed in the health service providers. Activities will be planned and commissioned around the HSE goal of integrated patient care and it is critical that the CPD systems of all relevant professions reflect the need for integration with other health services. In demonstrating the outputs of the CPD system, the contribution to integrated patient care and overall patient safety and outcomes must be an important focus.

12.3 Benchmarking patient safety

There therefore exists an opportunity upon the launch of a new system to benchmark and track progress in improving patient safety and patient outcomes. We have noted how there is limited evidence of the actual impact of CPD systems and a longitudinal study of this kind would establish a robust means of measuring this impact. It would also help to demonstrate how the role of the pharmacist is evolving and working with other health professional to deliver integrated patient care at community level. In Figure 12.2 we provide some initial thinking on how the contribution of pharmacy to wider healthcare impacts might begin to be tracked over time.

Figure 12.2: Benchmarking the Links Between the Pharmacist, CPD, Competency and Patient Safety



The diagram links the needs and characteristics of pharmacists to a tailored CPD framework that then helps to maintain and develop competencies. These competencies should interact with those of other professions to deliver integrated healthcare that will ultimately improve patient safety and patient outcomes. This in turn should lead to recognition of the evolving role of pharmacy in healthcare delivery, reaffirming its critical contribution to these impacts.

Benchmarking these impacts is complex. It will require comprehensive ongoing profiling of the characteristics, needs and skills of pharmacists. The scale and nature of engagement in the CPD system must also be measured, alongside the focus and appropriateness of CPD activities. The outcomes from CPD in terms of maintaining or developing competency must be gauged from practice review, post-activity testing and self-assessment exercises It might also require ongoing survey or consultation exercises with pharmacists, other health professionals and patients to monitor these relationships effectively.

All of this analysis is worthwhile because it underlines the fundamental purpose in introducing the CPD system: to protect patient safety and improve patient outcomes. It reaffirms the needs identified in this report for a model that:

- is based on clear standards of practice
- assesses and ensures the competency of the profession against these standards
- encourages inter-disciplinary working to realise wider healthcare objectives
- facilitates practitioner development and encourages pursuit of excellence
- recognises a wide range of activities to meet the needs of a diverse profession

If this can be put in place, we believe it has the ability to enact real change in the reputation and profile of the profession. It will build on the expertise that already exists to place pharmacy at the centre of effective healthcare delivery, contributing to real improvements in patient safety and outcomes.

Appendix A: Glossary

Term	Definition
Accreditation	The decision that a provider has met quality, educational and other criteria set out by the accrediting body
Activity	An educational event for professionals which is based upon identified needs (a needs assessment), has specified educational objectives and is evaluated to demonstrate that the needs have been met
Appraisal	An ongoing, two-way process involving reflection on an individual's performance, identification of education needs, and planning for personal development. The focus is on the appraisee and his or her professional development needs.
Approval	The process of evaluation of the quality and educational value of a CPD event. Sometimes the term "accreditation" is used for this
Audit (clinical)	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Audit (general)	An evaluation of a person, organization, system, process, project or product, performed to ascertain the validity and reliability of information, and also provide an assessment of a system's internal control
Assessment	Assessment is the measurement of the performance of an individual at a particular point in time, usually against pre-determined standards Assessments measure progress based on relevant curricula, and the results of assessment may feed into appraisal if appropriate. *(BMJ,* Appraisal: a guide for medical practitioners)
Competency	This term is used to encompass knowledge, skills, attitudes, behaviours and performance. The effectiveness of a CPD activity may be evaluated by documenting a change in one or more competencies. However, this is not the only way of evaluating effectiveness.
Compliance	Participants are meeting their requirements

Continuing Education Unit	The CEU is a universal method of measuring and granting credit for participation in continuing education programmes for professionals both within and outside healthcare. One CEU is equivalent to ten (10) contact hours of participation in organized continuing education under responsible sponsorship, capable direction and qualified instruction. The CEU is used particularly by those in a licensed profession in order for the professional to maintain the license.
Continuing Education:	A structured process of education designed or intended to support the continuous development of pharmacists to maintain and enhance their professional competence. Continuing education should promote problem-solving and critical thinking and be applicable to the practice of pharmacy. [99]
Continuing Professional Development:	Is the educative means of updating, developing and enhancing how professionals apply the knowledge, skills and attitudes required in their working lives., including continuing education. A self-directed, ongoing, systematic and outcomes-focused approach to learning and professional development. CPD includes but goes beyond CE. [100]
CPD Activity	An educational event or product (activity) for professionals, which is based upon identified needs, has an educational purpose-or objectives, and is evaluated to ensure that defined educational or professional development needs are met.
CPD Approval	The decision that an event or product (activity) has met the requirements for CPD
Credits	The term given to a unit of CPD activity. Credits may be determined in a number of ways, including the simple formula whereby one hour of activity gains one credit.
Distance learning	The provision of education through print or electronic communications media to professionals engaged in learning at a time and place of their own choosing and at a distance from a presenter, facilitator or tutor. The education may be web-based or fixed-format (e.g. CD-ROM).
Enduring materials	The fixed format methods of delivering Distance Learning including printed, recorded, audio and video products that may be used over time at various locations and which, in themselves, constitute a CPD activity
Evaluation form	A form given by event providers to event participants in order for the participant to communicate, and the provider to determine, the relevance, quality and effectiveness of an activity.

[99] http://www.farmasi.uio.no/vett/Jubileum/Silva.pdf

[100] http://www.farmasi.uio.no/vett/Jubileum/Silva.pdf

Formal learning	Learning typically provided by an education or training institution, structured (in terms of learning objectives, learning time or learning support) and leading to certification. Formal learning is intentional from the learner's perspective[101].
Informal learning	Learning resulting from daily life activities related to work, family or leisure. It is not structured (in terms of learning objectives, learning time or learning support) and typically does not lead to certification. Informal learning may be intentional but in most cases it is non-intentional (or "incidental"/ random) [102].
Journal based CPD	A specifically identified article within a peer-reviewed professional journal that serves as a planned learning activity and meets specific pre-defined educational quality criteria
Lifelong Learning:[103]	All learning activity undertaken throughout life, with the aim of improving knowledge, skills and competence, within a personal, civic, social and/or employment-related perspective.
Live activities	CPD activities that a professional attends in person (in the USA attendance may be virtual), eg live formal lectures, workshops and postgraduate residency programmes
National Accreditation Authority	The organization in an individual country responsible for the approval or accreditation of CME/CPD activities taking place within that country. NAAs also have a responsibility for the decision whether or not to grant CPD credits to doctors from that country who access or attend a CPD activity outside the country.
Needs Assessment	A process of acquiring and analyzing data that reflect the need for a particular educational activity. An evaluation of the difference between current and required knowledge, skills, attitudes or behaviours - used to determine priorities in developing educational activities and their defined learning objectives
Non-formal learning	Learning that is not provided by an education or training institution and typically does not lead to certification. It is, however, structured (in terms of learning objectives, learning time or learning support). Non-formal learning is intentional from the learner's perspective. [104].
Outcome	A change in knowledge, skills attitude or behaviour as a result of participation in a CPD activity

[101] Communication from the Commission: Making a European Area of Lifelong Learning a Reality, Brussels, 21.11.2001 COM(2001) 678 final

[102] Communication from the Commission: Making a European Area of Lifelong Learning a Reality, Brussels, 21.11.2001 COM(2001) 678 final

[103] http://www.farmasi.uio.no/vett/Jubileum/Silva.pdf

[104] Communication from the Commission: Making a European Area of Lifelong Learning a Reality, Brussels, 21.11.2001 COM(2001) 678 final

Peer Review	A review of educational or other scientific material or of an individual's professional activity by one or more people who are in the same professional field and have expertise in that field
Performance Improvement	A change towards recognized evidence-based best practice demonstrated by an individual over time. Performance represents the behaviour of the individual in the setting of professional practice.
Portfolio	A range of professional activities carried out in the past and present by an individual. These activities include learning and professional development.
Profession	An occupation, vocation or career where specialized knowledge of a subject, field, or science is applied.
Regulatory body	A National organisation responsible for the professional practice of doctors in that country. This may be a government body or an independent regulator.
Revalidation	The process, normally carried out by a Regulatory Body that allows a doctor to continue to practice for a defined period (Relicensure) or maintain his/her specialist certification
Sanctions	A restriction applied to a CPD provider or organiser as a consequence of the infringement of regulations regarding approval criteria

Appendix B: Stakeholders Consulted

Mr. Andrew Barber, Galway University Hospital

Mr. John Bourke, Pharmacist

Mr. Tom Concannon, Hickeys Pharmacy

Ms. Elaine Conyard, HPAI

Mr. Shaun Flanagan, HSE

Dr Paul Gallagher, RCSI

Ms. Liz Hoctor, IPU

Mr. Tom Kearns, Bord Altranais

Prof John Kelly, RCSI

Prof Julia Kennedy, UCC

Ms. Marita Kinsella, Department of Health and Children

Ms. Pamela Logan, IPU

Prof Anita Maguire, UCC

Prof Marek Radomski, TCD

Dr Ambrose McLoughlin, PSI

Mr. Ciaran Meegan, Mater Misericordiae University Hospital

Mr. Tom Monks, Department of Health and Children

Mr. Niall O'Shea, GSK

Mr. Jonathan Oakes, Waterford Regional Hospital

Ms. Rita O'Brien, Dublin Institute of Technology

Dr Siobhan O'Halloran, Nursing Services, HSE

Mr. Jackie Reed, HSE

Mr. Kieran Ryan, RCSI

Ms .Sheila Ryder, TCD

Mr. Noel Stenson, Nominee of the ICCPE

Ms. Judith Strawbridge, RCSI

Prof Arthur Tanner, RCSI