

# Continuing Fitness to Practise Pilot

A Report for the General Pharmaceutical Council

## Evaluation Report





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This evaluation has been based on information and data provided by, and reports prepared by, a number of third parties. While care was taken in the preparation of the information in this report and every effort has been made to ensure the information is accurate and up-to-date, SPH accepts no responsibility for gaps or limitations in the information.

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# 1 Executive Summary

## 1.1 Background and aims

The General Pharmaceutical Council (GPhC) is responsible for the standards of practice of pharmacy professionals in the UK and currently requires that they complete a range of reflective CPD entries each year. In order to increase reflection on learning and practice, and to ensure that improvements are made that benefit patients and service users, as well as to increase assurance for the public, the GPhC has piloted a new continuing fitness to practise (CFtP) framework which includes fewer CPD entry requirements but the addition of a case study and a peer discussion. SPH was commissioned to evaluate whether this:

- encourages participation, and reflection on learning and practice
- is fair and equitable
- is felt to be robust and proportionate and reassuring to the public
- does not entail untoward costs
- does not entail unexpected negative consequences.

## 1.2 Methods

In order to do this, SPH developed (together with the GPhC) a logic model for this evaluation and used a mixed methods approach, including an online survey, telephone interviews, analysis of entries to the CFtP database and a focus group, to answer the questions posed by the logic model.

## 1.3 Key Findings

1,346 pharmacy professionals agreed to take part in the pilot. Of these, 894 (66%) made at least one entry into the pilot CFtP database and 580 (43%) completed all six required entries (four learning activities, a case study and a peer discussion).

602 (67%) of the participating pharmacy professionals completed the online survey. Their responses, together with over 400 entries into the CFtP database, were evaluated. 23 telephone interviews were carried out, including with pharmacy professionals, peers and employers, and a focus group was held with nine members of the GPhC's Patient and Public Advisory Panel. Key findings are presented below in relation to each of the ten main questions in the logic model:

### 1.3.1 The proposed approach is simple to use

The view expressed by a majority of participants was that the proposed framework was very easy and intuitive to use, and easier to use than the current CPD system.

A number of participants felt that more support within the software, such as on-screen prompts, would be helpful.

Some participants found it difficult to identify appropriate case studies, peers or a topic for the peer discussion. This tended to be related to their understanding of the requirements, and further guidance is likely to help.

Analysis of entries to the pilot database found that generally participants recorded relevant information for each type of entry, although clarification may be helpful around documenting the relevance of the activity undertaken to their role, giving descriptions of what was learnt, and explaining the rationale behind their choice of peer.



The GPhC requested examples of how learning benefited patients or service users. In some cases, where benefits were expected in the future, this was not straightforward and clarification in the guidance or reminders to update entries might help with this.

### 1.3.2 The proposed approach encourages participation

A number of respondents reported that the proposed framework made them feel more positive about recording their learning and development activities, partly because they found it easier and quicker, leaving more time for reflection. The narrative style allowed them to “tell the story”, and felt less like a “tick box” exercise. Evidence suggested that entries were recorded closer to the time of the learning activity.

Barriers for some included time and whether or not employers supported the completion of entries during working hours. Employers appeared to understand the need for pharmacy professionals to maintain their fitness to practice and were supportive of this, for example by making online training available. However, the amount of time allowed varied and CFtP was generally felt to be the responsibility of the pharmacy professionals. Pharmacy professionals reflected this expectation.

### 1.3.3 The proposed approach encourages reflective learning, demonstrates an impact on patients or service users and where appropriate, is reflective of the GPhC Standard 3 – Communicate Effectively

Reflective practice has been defined by the GPhC as “the critical evaluation of practice and learning to find ways to improve outcomes for patients and service users”.

Many participants reported that their learning had been reflective to a greater degree than with the current CPD system, and felt it was useful to have a CFtP framework that encouraged this. All peers interviewed reported that their conversations had supported reflective learning. Although the majority of participants reflected on their learning needs, more guidance might be useful regarding the need for activities to be relevant to their role.

The case study specifically required participants to reflect on the GPhC Standard around communicating effectively. In 77% of entries that were assessed this was done but some found this challenging, often due to a perception that this requirement related to pharmacy professionals in patient-facing roles. Guidance on this could be strengthened.

Most participants understood the need for learning to benefit patients and service users. Although the vast majority described the application of their learning to their practise and many described actual impacts, in many cases the benefits were expected in the future.

### 1.3.4 The proposed approach incurs negligible additional time and other costs

Although a review of the full costs of implementation of the proposed framework was outside the scope of this evaluation, there was evidence that the primary cost to a participant is in terms of their time, rather than financial or the costs of other resources.

Making planned and unplanned learning entries in the proposed database was reported to take less time than in the current system. For peer discussions and case studies, the time taken varied. The peer discussion itself took under two hours in 95% of cases, with the majority (81%) of respondents reporting that the whole process, including making arrangements etc. took under 5 hours to complete, although for 3% of respondents this total time taken was over 15 hours. Case studies took less than two hours to complete for 81% of respondents, including the time taken to reflect on what to include. Peer discussions also had a time implication for some employers.



The majority surveyed considered the proposed framework to be proportionate. Interviewees generally felt that overall there was little or no additional time or cost impact, and that once they got used to the new concepts of peer discussion and case studies, these would be as straightforward as the other more familiar elements.

### 1.3.5 The proposed approach is fair and equitable

Analysis of participation rates suggested that pharmacy technicians were significantly less likely than pharmacists to complete entries for all four types of activity. As this was true of planned and unplanned learning entries as well for case studies and peer discussions, it may be that pharmacy technicians also engage less well with the current CPD system, and it may be possible for the GPhC to investigate whether this is the case. People who identified themselves as being of Indian ethnicity were also less likely than average to complete unplanned learning and peer discussion entries.

Some participants felt that their particular setting or role made it more difficult to identify appropriate peers and/or topics for peer discussions or case studies. However, the difficulty may in fact be more related to their interpretation of the guidance provided, and example entries from a wider range of settings was suggested. In addition those who had recently changed roles might benefit from support in identifying a peer.

A selection of questions from the online survey were analysed by characteristic, such as setting, gender and ethnicity and no systematic differences were found, although some results of interest are presented in the main report.

### 1.3.6 Participants understand the rationale for and requirements of the proposed approach

Overall, feedback suggested that the guidance was clear and unambiguous, and participants referred to it frequently and understood what was required. A few requested more clarity around case studies and peer discussion and around the level of detail required.

Interviewees were asked to describe what they understood by the term 'reflective learning', and responses were consistently in line with the definition provided by the GPhC ("the critical evaluation of practice and learning to find ways to improve outcomes for patients and service users").

Misunderstandings were most frequent around the use of the term 'case study,' with some considering it to mean a clinical case study, and around the term 'peer discussion,' with some using the more judgmental term, 'peer review,' instead. However, when asked what benefits and outcomes interviewees hoped to achieve from peer discussions, expectations were aligned to those of the GPhC. Peers themselves had varying understanding of their role, and guidance for peers would be helpful.

The role of other professional bodies and training organisations and the relationship between these and the proposed CFtP framework could be made clearer in the guidance.

### 1.3.7 The proposed approach is seen by stakeholders as providing assurance of fitness to practice

The majority felt the proposed framework to be robust in providing assurance to patients and the public. The majority of concerns related to the fact that it is based on trust. However, compared to the current CPD system it was felt that peer discussions added robustness by involving a named third party, as did case studies by requiring a "real life example." In the



focus group, Patient and Public Advisory Panel members also expressed confidence in the robustness of the framework, albeit raising similar issues regarding trust.

### 1.3.8 Peer discussions are robust and appropriate

Many participants reported that their peer discussion was very positive, in many cases unexpectedly so. They noted that they had gained new insights which they could apply to their service and that their confidence had grown as a result.

For some, the goal of 'reflective practise' through peer discussion may need further emphasis in the instructions to participants, as well as guidance for peers in how to frame feedback. However, most interviewees felt that they had been able to have a full and frank discussion with their peers.

### 1.3.9 Each element of CFtP meets its' objectives

The analysis of entries suggests that useful learning was being carried out, and many provided evidence of the impact of learning. Peer discussions appear to encourage reflection and have a positive impact on practise. Fewer entries were made for case studies, suggesting that these were more difficult for participants. However, telephone interviewees were largely positive about case studies and all felt that they had made positive changes to practise as a result. Similarly, all interviewees were confident that their unplanned learning examples had met their objectives, some noting a resulting change. All interviewees had examples of planned learning, often several. They tended to be clear on what was expected of these entries and felt that the examples they provided met the objectives and resulted in improvements in practise, although one suggested more clarity about what the GPhC was looking for. Similar feedback was obtained from the online survey, with most feeling that the proposed framework was more helpful than the current system in improving outcomes for patients and service users, although the percentage who said that their case studies were very or quite helpful in this was lower than for the other types of learning activity.

### 1.3.10 Any unexpected consequences are identified

As had been hoped by the GPhC, several participants reported being pleasantly surprised by how much they enjoyed completing their entries and that this made them feel more motivated to make entries early. For some, this was because of the more narrative format for entries, which they found more fulfilling and prompted more reflection. Although a small number of respondents preferred the current CPD system as it gave them more direction regarding entries, many more felt that the proposed framework was an improvement. Reasons for this include its flexibility, relevance, the reduction in time required, the ease of recording and the emphasis on reflective learning. These resulted in other positive outcomes, such as greater ownership of their professional development and a feeling that it was more worthwhile and personal.

## 1.4 Discussion

Overall this evaluation of the pilot suggests that the proposed CFtP framework offers significant benefits over the current system, particularly around increasing reflective learning and improving services and outcomes for patients and service users, as well as increased assurance to patients and the public. The simplification of the requirements for recording learning activities and the addition of a peer discussion and, to a lesser extent, the case study, helped. Participants mainly found the framework easy to understand and use and overall it was not felt to increase the time required above that of the current system.





The main recommendations made are around the supporting information and guidance provided, particularly for case studies and peer discussions, support for certain groups such as pharmacy technicians and further monitoring post implementation regarding equity.



## 2 Introduction

### 2.1 Structure of this Report

Following descriptions of the aims of this report, the GPhC CFtP pilot including its aims, and the research methods used for this report, cross-cutting issues of participation rates, communications and time and cost impacts are explored. The sections that follow this give more detail of each of the research methods used, including the full methodology and findings for each. These methods were:

- phone interviews
- an online survey
- analyses of entries made into the pilot database
- a focus group

Finally, a comparison of the GPhC approach with that of other regulatory organisations is presented.

### 2.2 Aims of this evaluation

The purpose of this evaluation is to explore how well the pilot framework has met its objectives. Further, the GPhC recognises that the CFtP framework should offer equal benefit to all pharmacy professionals, and so is seeking to understand any barriers or enablers to participation encountered by particular groups.

As the software for the pilot database is not that which will be used in the final framework, the evaluation excludes any assessment of this software or technical issues surrounding its use. However, any feedback around these issues which has been received incidentally has been collated separately for future consideration by the GPhC.

### 2.3 About the Pilot

In 2018, the GPhC plans to introduce new arrangements to further assure that pharmacists and pharmacy technicians meet standards for safe and effective practice throughout their careers. The GPhC has been developing proposals over the last few years and has recently completed a pilot exercise to test these proposals with a wide group of pharmacists and pharmacy technicians so that they can better understand their impact. This pilot ran from April 2016 to December 2016.

During the pilot, participants were asked to:

- Record four CPD entries in a new, simplified recording format
- Carry out and record a peer discussion
- Produce a case study of a change related to Standard 3 of the *Standards for Pharmacy Professionals* that has benefited patients or service users

#### 2.3.1 Aims of the pilot

The GPhC has established from a number of sources that members of the public would like to have further assurance that health professionals (including pharmacy professionals) are safe and effective beyond initial registration. To meet this expectation, the GPhC has been trying to understand what pharmacy professionals already do to maintain and develop their knowledge and skills, and how these might be used to provide that further assurance. In 2015 and 2016 they undertook research and testing of options. This demonstrated that they can do



more to encourage reflection on learning and practice in some innovative ways. The pilot framework is being used to test these with a wide group of volunteer pharmacy professionals.

Core aims of the proposed CFtP framework include encouraging and strengthening the following behaviors among pharmacy professionals in a somewhat more explicit way than is the case with the current CPD system:

- further demonstrating a patient or service-user centered approach
- further demonstrating *reflective* learning
- demonstrating how they have applied what they have learnt
- valuing CFtP as a regular activity

Specific changes have been made in the CFtP pilot that differentiate it from the current CPD system, in order to support these aims. These are primarily:

- introducing a case study element, where participants are asked to provide an example of their own choice of where they have improved their practice, reflecting the application of the GPhC Standards. For the purposes of the pilot, the case study needed to relate to the GPhC Standard 3 – communicate effectively. Moving forward, participants will be able to choose which GPhC standard or standards to reflect in their case study. They were also asked to demonstrate why they chose this topic and how they have applied their learning
- introducing a peer discussion element, where participants are asked to describe how they have reflected on their practice and learning with a peer
- asking participants to demonstrate how their learning has been reflective, patient/service-user centered and applied to their practice throughout all their CFtP entries
- simplifying the database entry, cutting out duplication and reducing the number of 'tick box' questions
- allowing scope for participants to provide more narrative responses

## 2.4 Research Methods

In agreement with the GPhC, SPH adopted a mixed-methods approach to this evaluation, comprising of:

- An online survey of pilot participants (894 pharmacy professionals)
- A focus group held with 9 members of the GPhC patient and public advisory panel
- An analysis of a sample of records entered by participants into the pilot database
- Telephone interviews with –
  - 14 pharmacy professionals participating in the pilot
  - 7 employers of pharmacy professionals participating in the pilot
  - 4 individuals who have acted as peers in the peer discussion element of the pilot framework
  - 1 pharmacy professional not participating in the pilot, to gain an external perspective
- In addition, SPH has compared key elements of the GPhC approach to the approaches taken by other regulatory organisations, to contextualise the information above

This evaluation was completed by the end of January 2017, so as to be available to support the GPhC in their decision making about next steps. The GPhC further requested an Interim Report to be provided in November 2016, also to support their decision making. This has meant that the information gathering activities detailed above were carried out while the pilot

was running. Information gathering was therefore phased, so as to provide initial information to inform the Interim Report (phase 1), and to provide subsequent information based on the growing cohort of participants who had completed all requisite pilot activities, for inclusion in this final report (phase 2). Further details are given in Appendix 2: Phasing of key evaluation project activities

## 2.5 Evaluation Logic Model

These activities have been informed by a logic model. Initially created by the GPhC, this was expanded on by SPH and formed a framework which was referred to when determining what questions need to be asked via which method and of which stakeholder group. The desired outcomes of the pilot are described in this logic model, and formed the basis of question areas. These outcomes, as identified within the logic model, are shown in Table 1 below.

**Table 1: Desired outcomes of the pilot, as defined in the Logic Model**

Outcome Desired	
1	The proposed approach is simple to use
2	The proposed approach encourages participation
3	The proposed approach encourages reflective learning, demonstrates an impact on patients or service users and where appropriate, is reflective of the GPhC Standard 3 - Communicate Effectively
4	The proposed approach incurs negligible additional time and other costs
5	The proposed approach is fair and equitable
6	Participants understand the rationale for and requirements of the proposed approach
7	The proposed approach is seen by stakeholders as providing assurance of fitness to practice
8	Peer discussions are robust and appropriate
9	Each element of CFtP meets its' objectives
10	Any unexpected consequences are identified

## 2.6 Analyses by Characteristic

In order particularly to establish whether the proposed CFtP framework worked in a fair and equitable way (Outcome 5 above), where possible, analyses were carried out in which participants were grouped according to a number of characteristics. These characteristics were:

- Role (pharmacist or pharmacy technician)
- Setting of practice
- Sex
- Country
- Full time or part time
- Whether a locum
- Number of years registered
- Whether disabled
- Ethnicity



- Whether the person had English as a second language (this was addressed in the online survey only, where a question was asked about whether this had affected their ability to complete the pilot if this was the case)
- Whether in a portfolio role (more than one)

## 3 Review of Participation Rates

### 3.1 Introduction

Participants in the pilot were asked to:

- Record four CPD entries in a simplified recording format
- Carry out and record a peer discussion
- Produce a case study of a change to practice that has benefited patients or service users, which related to the GPhC Standard 3 'Communicate Effectively'

Entries detailing these activities needed to be entered into the pilot database by the 31st December 2016. In return for taking part in the pilot, participants are excluded from CPD record calls in 2016 and 2017.

### 3.2 Methodology

Following the 31<sup>st</sup> December 2016 deadline, entries on the pilot database were analysed to evaluate:

- How many people signed up to take part in the pilot, and some of their characteristics
- How many of those who had signed up to taking part in the pilot had taken part (defined as having completed at least one entry in the database)
- How many of those who had taken part, had completed all the required entries
- What proportion of different subgroups of participants completed the different types of entries, including subgroups by gender, ethnicity, practice setting, etc.

Confidence intervals for proportions were calculated using the Wilson score method as published by the Association of Public Health Observatories<sup>1</sup>

### 3.3 Results

#### 3.3.1 How many pharmacy professionals signed up to take part in the pilot?

Prior to recruiting pharmacy professionals for the CFtP pilot, the GPhC calculated the minimum and maximum numbers that they aimed to recruit among different professional groups such as pharmacists and pharmacy technicians. This was based on the current profile of pharmacy professionals nationally, whilst also taking into account the need to have sufficient numbers in some of the smaller groups for them to be adequately represented in the evaluation of the pilot. Table 2 shows the breakdown of the people who signed up to take part in the pilot by subgroup, who participated in the pilot and who completed all requirements of the pilot. Table 3 shows how the percentages in each group compare with the percentages that relate to the minimum and maximum numbers that it was hoped would take part and the numbers that completed at least one entry and that completed all required entries.

1,346 people signed up to take part in the CFtP pilot. This included pharmacy professionals in a wide range of settings and across many different groups such as locums, people who worked part time, etc. In some groups the numbers were relatively small, for example people with disabilities (23 pharmacy professionals signed up) and those with a portfolio role (35).

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<sup>1</sup> Analytical tools for Public Health, Association of Public Health Observatories, February 2014 [www.apho.org.uk/resource/view.aspx?RID=48617](http://www.apho.org.uk/resource/view.aspx?RID=48617)



Overall, more people were recruited to take part in the pilot than was planned (1,346 compared to the maximum number planned of 1186). The number who actually participated in the pilot (completed at least one entry) was higher than the minimum that had been hoped for (894 compared to 814), and 580 completed all required entries.

The composition of the group that was recruited and the group that actually participated in the pilot was compared with the GPhC's recruitment target. Compared to this, fewer pharmacy technicians signed up and participated in the pilot than the GPhC had hoped. Another group that was less well represented in the pilot compared to the recruitment target was locums.

Please note that when carrying out analysis by ethnicity, three groupings have been used: British, Indian and 'Other'. This is because there are low numbers of individuals self-reporting as belonging to each of the fourteen categories included under 'Other' (for example, Irish, Bangladeshi, White and African etc.), making meaningful analyses by these categories difficult. For example, the category with the largest number of pharmacy professionals volunteering to be part of the pilot other than British and Indian was African, with 31 individuals, or 2% of the 1,346 who volunteered.



**Table 2: The composition of the pilot cohort: Number of people who took part in the CFtP pilot in each subgroup, compared to the recruitment target where available**

Pilot participant Subgroups	Minimum recruitment target number	Maximum recruitment target number	Number who signed up to participate in the pilot	Number completing at least one pilot entry	Number completing all required pilot entries**
Total number	<b>814</b>	<b>1186</b>	<b>1346</b>	<b>894</b>	<b>580</b>
Roles:					
Pharmacists	510	696	1045	726	495
Pharmacy Technicians	304	490	301	168	85
Primary Setting:					
Academic / educational	17	30	111	79	63
Hospital	236	353	333	228	138
Independent community pharmacy			189	117	76
Multiple community pharmacy	306	441	401	241	161
Primary care / GP practice	49	71	169	129	80
Advisory / regulatory			66	55	38
Other setting			77	45	24
Other Community <sup>#</sup>	223	324			
Independent <sup>#</sup>	100	144			
Country:					
England	711	1042	1062	702	453
Scotland	61	89	211	148	102
Wales	42	55	73	44	25
Gender:					
Female	580	859	933	624	424
Male	234	327	412	269	155
Full time / part time:					
Full time			982	643	408
Part time			303	210	145
Locum:					
Yes	131	200	70	43	26
No	510	696	1276	851	554
Ethnicity:					
British			975	668	440
Indian			130	75	44
Other*			203	132	96
Disability:					
Yes			23	14	8
No			1306	873	569
Portfolio:					
Yes			35	27	16
No			1311	867	564

Source: Data supplied by GPhC, January 2017

\* As noted above, this 'Other' category incorporates individuals who have self-reported as belonging to one of 14 available ethnic groupings other than British and Indian

\*\* One case study, one peer review and four learning activities of which at least 2 were planned

# Some of this group may be included in other groups above

Note that recruitment target numbers were not decided for all of the above groups, hence some blanks in the table.



**Table 3: The composition of the pilot cohorts: the proportion of the total in each subgroup**

Pilot participant Subgroups	Target composition of group relating to minimum target numbers	Target composition of group relating to maximum target numbers	Composition of group that signed up to take part in the cohort	Composition of group that completed at least one pilot entry	Composition of group that completed all required pilot entries**
Total number	<b>814</b>	<b>1186</b>	<b>1346</b>	<b>894</b>	<b>580</b>
Roles:					
Pharmacists	63%	59%	78%	81%	85%
Pharmacy Technicians	37%	41%	22%	19%	15%
Primary Setting:					
Academic / educational	2%	3%	8%	9%	11%
Hospital	29%	30%	25%	26%	24%
Independent community pharmacy			14%	13%	13%
Multiple community pharmacy	38%	37%	30%	27%	28%
Primary care / GP practice	6%	6%	13%	14%	14%
Advisory / regulatory			5%	6%	7%
Other setting			6%	5%	4%
Other Community <sup>#</sup>	27%	27%			
Independent <sup>#</sup>	12%	12%			
Country:					
England	87%	88%	79%	79%	78%
Scotland	7%	8%	16%	17%	18%
Wales	5%	5%	5%	5%	4%
Gender:					
Female	71%	72%	69%	70%	73%
Male	29%	28%	31%	30%	27%
Full time / part time:					
Full time			73%	72%	70%
Part time			23%	23%	25%
Not stated			5%	5%	5%
Locum:					
Yes	16%	17%	5%	5%	4%
No			95%	95%	96%
Ethnicity (self-defined):					
British			72%	75%	76%
Indian			10%	8%	8%
Other*			15%	15%	17%
Not stated			3%	2%	0%
Disability:					
Yes			2%	2%	1%
No			97%	98%	98%
Not stated			1%	1%	1%
Portfolio:					
Yes			3%	3%	3%
No			97%	97%	97%

\* As noted above, this 'Other' category incorporates individuals who have self-reported as belonging to one of 14 available ethnic groupings other than British and Indian

\*\* One case study, one peer review and four learning activities of which at least 2 were planned

<sup>#</sup> Some of this group may be included in other groups above

Source: Data supplied by GPhC, January 2017

### 3.3.2 How many of those who signed up actually took part in the pilot?

Overall 66% of those who signed up to take part in the pilot completed at least one entry and 43% completed all required entries (defined as completing at least four CPD activities of which at least two were planned, one case study and one peer discussion) (Table 4).

When analysed by subgroup, the proportion completing at least one entry tended to be similar in all subgroups, with the lowest levels among:

- pharmacy technicians. The proportion was 56% (95% CI 50.2% – 61.3%) for pharmacy technicians versus 69% (95% CI 66.6% - 72.2%) for pharmacists. This difference was statistically significant (95% confidence intervals for the proportions do not overlap)
- those of Indian ethnicity. The proportion was 58% (95% CI 49.1% - 65.8%) for those recorded as Indian versus 69% (95% CI 65.5% - 71.4%) for those recorded as British. This difference was close to statistical significance.

This suggests that these two groups may have found participation in the pilot more difficult. See Appendix 3 for an explanation of confidence intervals and statistical significance.

When analysed by subgroup, the proportion completing all required entries was only 28% for pharmacy technicians (statistically significantly lower than average) and was highest for those in an academic / educational role at 57% (statistically significantly higher than average). Although not statistically significantly different from average, other groups that had relatively low proportions completing all required activities were participants from Wales ((34%), those recorded as Indian (34%), participants with a disability (35%) and locums (37%).



**Table 4: Engagement levels of the pilot cohort by subgroup: Number of people who signed up to, took part in, and completed the CFtP pilot, by sub-group**

Pilot participant Subgroups	Number who signed up to participate in the pilot	Number completing at least one entry	% completing at least one entry	Number completing all required entries	% completing all required entries
All	1346	894	66%	580	43%
Roles:					
Pharmacists	1045	726	69%	495	47%
Pharmacy Technicians	301	168	56%*	85	28%*
Primary Setting:					
Academic / educational	111	79	71%	63	57% <sup>\$</sup>
Hospital	333	228	68%	138	41%
Independent community pharmacy	189	117	62%	76	40%
Multiple community pharmacy	401	241	60%	161	40%
Primary care / GP practice	169	129	76% <sup>\$</sup>	80	47%
Advisory / regulatory	66	55	83%	38	58%
Other setting	77	45	58%	24	31%
Country:					
England	1062	702	66%	453	43%
Scotland	211	148	70%	102	48%
Wales	73	44	60%	25	34%
Gender:					
Female	933	624	67%	424	45%
Male	412	269	65%	155	38%
Full time / part time:					
Full time	982	643	65%	408	42%
Part time	303	210	69%	145	48%
Locum:					
Yes	70	43	61%	26	37%
No	1276	851	67%	554	43%
Ethnicity (self-defined):					
British	975	668	69%	440	45%
Indian	130	75	58%	44	34%
Other**	203	132	65%	96	47%
Disability:					
Yes	23	14	61%	8	35%
No	1306	873	67%	569	44%
Portfolio:					
Yes	35	27	77%	16	46%
No	1311	867	66%	564	43%

Source: Data supplied by GPhC, January 2017

\* Statistically significantly lower than average (95% confidence intervals do not overlap)

<sup>\$</sup> Statistically significantly higher than average

\*\* As noted above, this 'Other' category incorporates individuals who have self-reported as belonging to one of 14 available ethnic groupings other than British and Indian



### 3.3.3 How many of those who took part in the pilot completed each type of entry/activity?

Table 5 shows a breakdown of completed entries by subgroup for each type of activity (planned CPD, unplanned CPD, peer discussion and case study).

Overall, planned CPD entries were the most frequently completed, by 63% of those who signed up to the pilot, followed by unplanned entries (54%) and peer discussion (52%). Case studies were documented by the fewest (49%).

This pattern, of planned entries being completed most frequently and case studies least frequently, was seen in all groups.

The highest rates of completion of entries were as follows:

- For planned CPD entries it was among those with an advisory or regulatory role (82%, statistically significantly higher than average)
- For unplanned CPD entries it was among those working in primary care (65%, statistically significantly higher than average)
- For peer discussions it was seen among those in an advisory/regulatory setting and in academic/educational settings (65% and 63% respectively)
- For case studies the highest completion rates were seen among those in an advisory / regulatory and academic / educational settings (68% and 62% respectively, both being statistically significantly higher than average)

Pharmacy technicians tended to have the lowest rates of completion for all types of entries (52% for planned CPD, 46% for unplanned CPD, 39% for peer discussions and 34% for case studies). Rates of completion of each type of entry by pharmacy technicians were statistically significantly lower than the average rate for that type of entry.

People of Indian ethnicity (self-reported) also had relatively low rates of entry for each of the four types of activity and the rates were statistically significantly lower than average for both unplanned CPD (42%) and peer discussions (40%). The numbers in the other minority ethnic groups were too small to provide useful information.

Rates of entry of peer discussions and case studies onto the pilot database were relatively low among the 23 people with disabilities who signed up to take part in the pilot (43% and 39% respectively), although this was not statistically significant. The same is true for the 46% rate of recording of peer discussions among the 70 locums who signed up to the CFtP pilot.



**Table 5: Engagement levels in the pilot by type of activity and subgroup: % of those who signed up who completed an entry by type of entry and subgroup**

Pilot participant Subgroups	Total signed up for pilot	Planned entries		Unplanned entries		Peer discussions		Case studies	
		Number	% of those signed up	Number	% of those signed up	Number	% of those signed up	Number	% of those signed up
All	1346	847	63%	729	54%	697	52%	661	49%
<b>Roles:</b>									
Pharmacists	1045	691	66%	591	57%	579	55%	560	54%
Pharmacy Technicians	301	156	52%*	138	46%*	118	39%*	101	34%*
<b>Primary Setting:</b>									
Academic educational /	111	78	70%	60	54%	70	63%	69	62% <sup>§</sup>
Hospital	333	211	63%	194	58%	171	51%	162	49%
Independent community pharmacy	189	110	58%	93	49%	95	50%	85	45%
Multiple community pharmacy	401	232	58%	198	49%	194	48%	181	45%
Primary care / GP practice	169	121	72%	110	65% <sup>§</sup>	91	54%	88	52%
Advisory / regulatory	66	54	82% <sup>§</sup>	39	59%	43	65%	45	68% <sup>§</sup>
Other setting	77	41	53%	35	45%	33	43%	31	40%
<b>Country:</b>									
England	1062	662	62%	568	53%	541	51%	513	48%
Scotland	211	143	68%	127	60%	119	56%	116	55%
Wales	73	42	58%	34	47%	37	51%	32	44%
<b>Gender:</b>									
Female	933	592	63%	522	56%	500	54%	473	51%
Male	412	254	62%	207	50%	196	48%	187	45%
<b>Full time / part time:</b>									
Full time	982	608	62%	528	54%	495	50%	465	47%
Part time	303	199	66%	165	54%	170	56%	166	55%
<b>Locum:</b>									
Yes	70	41	59%	36	51%	32	46%	35	50%
No	1276	806	63%	693	54%	665	52%	626	49%
<b>Ethnicity:</b>									
British	975	639	66%	550	56%	531	54%	498	51%
Indian	130	69	53%	54	42%*	52	40%*	52	40%
Other	203	120	59%	110	54%	97	48%	96	47%
<b>Disability:</b>									
Yes	23	13	57%	12	52%	10	43%	9	39%
No	1306	827	63%	712	55%	683	52%	648	50%
<b>Portfolio:</b>									
Yes	35	26	74%	22	63%	20	57%	19	54%
No	1311	821	63%	707	54%	677	52%	642	49%

Source: Data supplied by GPhC, January 2017

\* Statistically significantly lower than average (95% confidence intervals do not overlap)

<sup>§</sup> Statistically significantly higher than average

Information was not provided by one participant for gender, 61 participants for full versus part time working, 38 for ethnicity, and 17 regarding disability.

## 3.4 Findings in relation to the Logic Model

### 3.4.1 Outcome 2: The proposed approach encourages participation

The figures above show the level of engagement / participation in the four types of activity in the CFtP pilot. The rate of completion of case studies was lower than for the other activities, and completion rates were highest for planned and unplanned learning entries. This may reflect the fact that, unlike planned and unplanned learning entries, case studies and peer discussion are new elements which are not as familiar to participants and may become easier over time. The completion rates for each activity in the pilot may not reflect what they would be in the final CFtP system however, because participants may have felt that if they did not engage with the pilot they would still have time to complete the old CPD requirements within the required timescale.

### 3.4.2 Outcome 5: The proposed approach is fair and equitable

The pilot included fewer pharmacy technicians and locums than had been hoped. Issues were highlighted with respect to lower completion rates by pharmacy technicians for all types of activity, and by people of Indian ethnicity for unplanned entries and peer discussions. Although not statistically significant, completion rates for people with disabilities, particularly for peer discussions and case studies, and for peer discussions by locums would also be worth monitoring over time. Any learning from the survey, interviews and analysis of entries that would help to understand these differences may be useful in improving equity in the longer term.

## 3.5 Conclusions and Recommendations

These results suggest that participants were less likely to complete case studies than the other types of entry. The survey and interviews provide information that helps to understand the reasons for this and what might be done to increase engagement with this element of the proposed CFtP process.

Pharmacy technicians who signed up to the pilot were significantly less likely than pharmacists to engage in any of the activities, and reasons for this need to be explored, together with potential solutions. It may be related to the fact that participation in the pilot was voluntary. Alternatively, as the lower response rate by pharmacy technicians was true for each of the four types of activity, it may be that pharmacy technicians also engage less well with the current CPD system, and it may be possible for the GPhC to investigate whether this is the case.

People of Indian ethnicity were less likely than average to complete unplanned CPD entries and peer discussions (and case studies, though the latter was not statistically significantly different from the average).

Although people with disabilities were less likely than average to submit entries relating to peer discussions and case studies, the differences were not statistically significant. This may be due to the relatively small numbers of people with disabilities who took part in the pilot. The same is true for completion rates of peer discussions by locums.

The GPhC may wish to monitor all these differences after the proposed CFtP framework, and any modifications made to the pilot, have been rolled out.

Note that the relatively low overall completion rates in the pilot may not reflect future rates when the system is rolled out because participation in the pilot was voluntary and participants may have assumed that if they do not complete all requirements of the pilot by the 31<sup>st</sup> December they would still be able to complete the previous CPD requirements in time for that deadline.

## 4 Review of Communications from the GPhC

### 4.1 Introduction

In order to achieve the overriding objectives of encouraging pharmacy professionals to demonstrate a more patient or service-user centred approach, to engage in greater reflective learning, to demonstrate how they have applied what they have learnt, and to see CFtP as a core part of their normal work, the GPhC made a number of changes to the CPD system. These are described in more detail below.

#### 4.1.1 Planned learning entries

Planned learning entries give participants the opportunity to demonstrate learning and development activities that have occurred in a planned way, where they have reviewed their practice to identify learning and development needs, and considered the most appropriate ways in which to address these.

They are core to the current CPD system and therefore retained in the CFtP pilot. However, the process was simplified, and duplication reduced. This allowed participants to record their learning in a more narrative format.

Participants are expected to demonstrate that they have reflected on their current practice to identify learning and development needs, and on the best way to meet these needs. They are also expected to demonstrate both how they have carried out their learning and development activities, and how they have then applied their new knowledge and skills in practice to improve the service they offer to patients and service users.

An underlying aim is to encourage the perception of learning and development as being part of a cycle of continual improvement.

#### 4.1.2 Objectives of Unplanned Learning Entries

Unplanned learning entries give participants the opportunity to demonstrate occasions where learning and development activities have occurred in a reactive way, in response to an event. For example, a community pharmacy customer may ask for advice about a particular medication, which flags to the participant that they have a gap in their knowledge which they then seek to address.

As with planned learning entries, these are core to the current CPD framework and therefore retained in the CFtP pilot. However, the process was simplified and a more narrative format of entry was supported.

Participants are asked to describe their learning event or activity, and to demonstrate what they have learnt, and how they have then applied their new knowledge and skills in practice to improve the service they offer to patients and service users.

The GPhC recognises that different settings and job roles offer varying opportunities for planned or unplanned learning. Unplanned learning in particular by its very nature relies on external prompts and cannot be planned for, and so is not demanded within the CFtP framework, which rather ensures there is a place to record this activity should it arise.

#### 4.1.3 Objectives of Case Studies

Case study entries have been introduced to allow participants to demonstrate where they have made positive changes to their practice, with specific relation to the Standards expected





of pharmacy professionals. Case studies are distinct from other types of entry in that while all entries require examples from practice, this is the primary focus of the case studies. In addition it needs to reflect application of the GPhC Standards for Pharmacy Professionals<sup>2</sup>.

For the pilot, participants were asked to reflect on just one standard: Standard 3 - Communication. This was to limit the scope, so as keep the changes being asked of participants to a manageable level. Over time, the intention is to expand this so that participants choose for themselves which standard or standards to demonstrate. By doing this, the GPhC aims to encourage pharmacy professionals to regularly review and reflect on the Standards, ensuring they remain uppermost in their minds.

#### 4.1.4 Objectives of Peer Discussions

In peer discussion entries, participants are asked to describe the processes they have gone through to engage in a peer discussion, and to show the reasons behind their choice of peer, how the discussion helped them to reflect on their practice, any subsequent changes to their practice and the benefits of any changes to their service users.

Two key objectives of peer discussion entries which differentiate them from other types of entry are to help reduce professional isolation, and to provide participants with a safe place to discuss areas of learning and development. To support the latter, the GPhC did not require participants to describe the subject of their peer discussions.

In addition, the GPhC aims to encourage the perception that, as in all professions, all pharmacy professionals have opportunities for further learning and development, regardless of their work setting, role or stage of their careers, and that an external view can be helpful in helping participants in reflecting on both what these needs may be and how they might best be addressed. Having a third party confirming positive aspects of your practice can also be an affirmative and confidence-giving process.

## 4.2 Analysis of communications from the GPhC about these objectives

The GPhC has communicated its expectations and reasoning to participants in a number of ways:

- Guidance documentation provided on-line to participants - Continuing Fitness to Practice Guidance to pilot volunteers (April - December 2016) v1.0, and Example entries for piloting CFtP, shown in Appendix 4. These are jointly referred to here as the guidance documentation
- Workshops held at a range of locations
- Establishment of an online forum, which was open from July 20<sup>th</sup> to August 17<sup>th</sup> 2017
- Telephone helpdesk and email query mailbox

For the GPhC to achieve its objectives and for participants to meet the expectations of the GPhC, these expectations need to be clearly and unambiguously articulated. This section explores how clearly the expectations outlined above were described in the guidance documentation provided by the GPhC to pilot participants.

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[https://www.pharmacyregulation.org/sites/default/files/consultation\\_on\\_standards\\_for\\_pharmacy\\_professionals\\_april\\_2016.pdf](https://www.pharmacyregulation.org/sites/default/files/consultation_on_standards_for_pharmacy_professionals_april_2016.pdf)



#### 4.2.1 Planned and Unplanned Entries

The GPhC guidance documentation was clear in demonstrating the expectation that participants were expected to complete planned and unplanned entries, and that the main differences between the CPD and CFtP frameworks are changes to the structure of the database. For example, the reduction in the number of entry points from four to two: planned and unplanned, and the reduction in the number of questions being asked.

It was clear that the GPhC was hoping to encourage learning that is relevant to the individual's work, and reflection on learning and development needs that is more effective and closer to the time of the learning activity, and that making the proposed framework more accessible and easy to use was a key mechanism to support this. The increased focus on demonstrating the impact of learning on the service given to patients and service users was also clear.

#### 4.2.2 Peer discussion

The GPhC was clear in the desire to encourage participants to engage with others in their reflection on learning and practice, and that their rationale was that this was both proven to be effective in helping professionals to improve their practice, and that it was intended to help reduce the potential for professional isolation.

The guidance explicitly stated that effective discussions would be "formative, open and honest and with someone who is trusted and respected." How and where the discussions would be held was left to the participant to decide, with no options precluded.

It was clearly stated that the content of the discussions could remain confidential, although only the example entries suggested that participants recorded who their peer was, for verification purposes. Both guidance documents asked participants to demonstrate that the discussion had led them to reflect on their practice and to show what difference the peer discussion had made to their practice. The difference in asking to report who the peer was between the example entries and the Continuing Fitness to Practice Guidance to pilot volunteers (April - December 2016), with the suggestion to record who the peer being made only in the example entries, was a potential source of misunderstanding.

#### 4.2.3 Case Study

The case study is a new element for participants, and a range of new concepts are introduced. Some elements of the guidance may benefit from being simplified, to ensure all new concepts are described separately. For example, the initial paragraph states that "Our approach to CPD encourages reflection on learning, but we also want to do more to encourage reflection on practice based on evidence". This sentence covers range of concepts.

The second (final) paragraph of the guidance relating to case studies begins: "The case study asks pilot volunteers to describe an example of a change to practice related to one of our new draft standards for pharmacy professionals." This is very clear and unambiguous, and may be best used as the introductory sentence.

It is suggested that a more explicit and detailed description of the aims of the case study and expectations from GPhC would be beneficial.

Section 4 of the Guidance provides participants with more information as to what the GPhC expects. For case studies, this part of the guidance reiterates earlier phraseology in the introductory paragraph and so previous comments apply.

The sentence, "We want you to produce a case study of a change to your practice that has benefited your patients or service users", is very clear, with the proviso that the term 'case



study' has not been explicitly defined. As it is a phrase used in a number of professional settings with very particular, and varying, definitions, it is suggested that the GPhC either select a different term, or provide a detailed definition.

The next sentence states "The topic you select for your case study should be different to the topics selected for your CPD submissions." This requirement was not stated for peer discussions, and not explained. The GPhC may therefore wish to consider giving further explanation of their rationale for this.

The next part of this sentence, "and should specifically relate the example to Standard 3 'Communicate effectively' of the Draft Standards for Pharmacy Professionals," is very clear. However, further explanation of the reasons for focusing on the Standards in the case studies may be helpful to participants, as may be making explicit that any CFtP entries may be used to demonstrate activities related to standards, but that the difference with the case studies is that this is a requirement. A link within the database to the Standards may also be helpful.

Finally, this paragraph ends with, "We want you to reflect on the change itself and, if possible, include information on how you have evaluated this impact." This phraseology is somewhat ambiguous. A clearer expectation may be that participants are asked to demonstrate a change they have made to their practice which has benefited patients or service users, and to describe what they consider to be the impact of this change, including any evidence if available. It may also be helpful to explain to participants that this change does not need to have resulted directly from a learning or development activity, but rather is aimed at their demonstrating that they are engaged in a cycle of continuous improvement of the service they provide to patients or service users.

### 4.3 Conclusions and Recommendations

While much of the guidance provided to participants is clear, there are some areas where more clarity could be provided, particularly as the peer discussion and case study are new to many participants.

It is suggested that the term 'case study' is reviewed, and a term without connotations applying to other settings used instead. Possible examples include "change in practice in relation to standards", "improvement in practice in relation to standards" or "an example of a change to practice that has benefitted patients or service users".

It is also suggested that the wording of guidance for case studies especially, and also for peer discussions, is reviewed, to ensure it is fully and clearly aligned with the objectives of these entry types.

It is suggested that where guidance is provided in different documents, these are fully aligned and consistent.

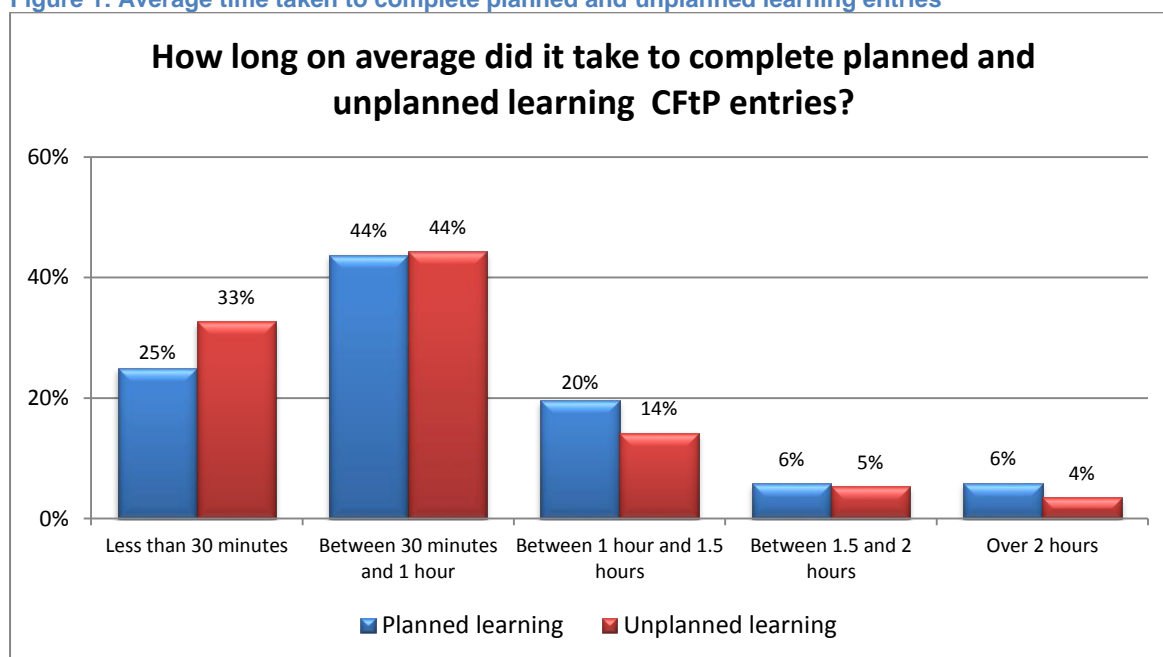
## 5 Time and Cost Impacts of the Proposed Framework for Registrants

The impacts of the proposed changes do not carry a cost directly for registrants, however they will have an impact on their time either at work or in their personal lives. Because pharmacy professionals already have a duty to undertake and record CPD activities and do so for a number of reasons, not limited to maintaining their registration, it is difficult to attribute a cost to these activities resulting from regulation. The evaluation therefore is focused on the time impact in relative terms to the current CPD requirements. Key findings shown here are presented in more detail in the findings relating to telephone interviews and the online survey.

### 5.1 Review of online survey findings

602 pharmacy professionals responded to the online survey. In this, they were asked **how long it took them to complete each of their planned and unplanned learning entries in the CFtP system**, including time to reflect on what to include (Questions 34 and 37). As shown in Figure 1 below, in most cases these took under 1 hour.

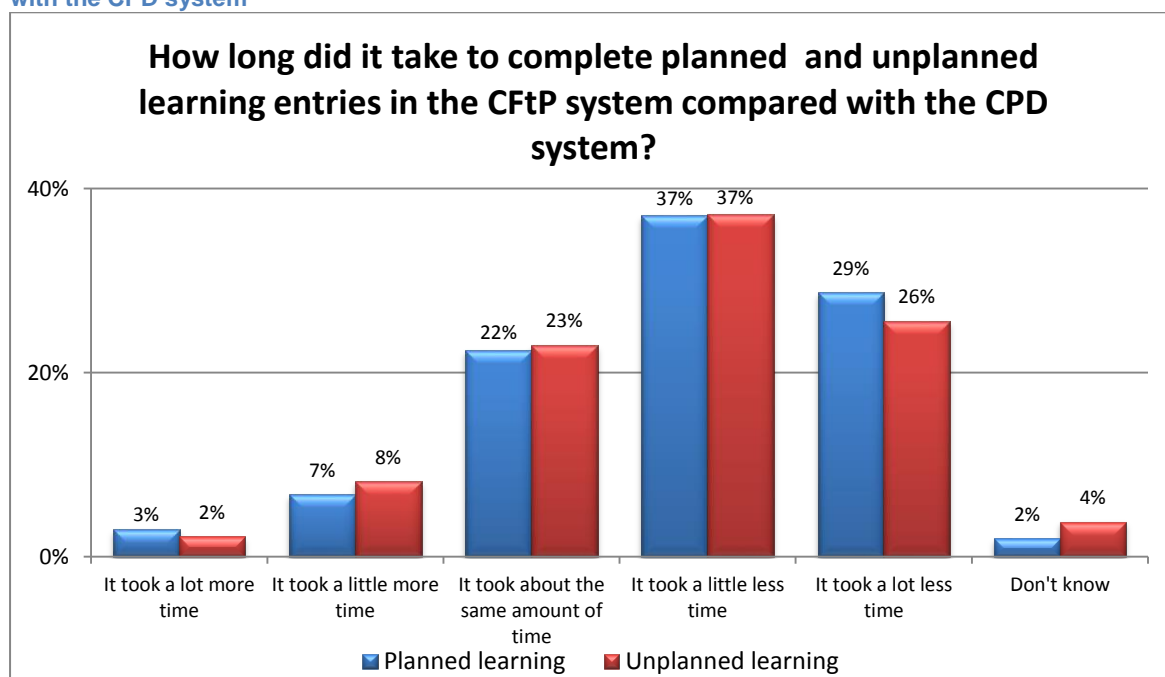
Figure 1: Average time taken to complete planned and unplanned learning entries



Source: SPH online survey, questions 34 & 37

The majority of respondents reported that it took less time to complete planned and unplanned learning entries in the CFtP system than in the CPD system (Questions 35 and 38), as shown in Figure 2 below, with 29% and 26% respectively noting that it took a lot less time.

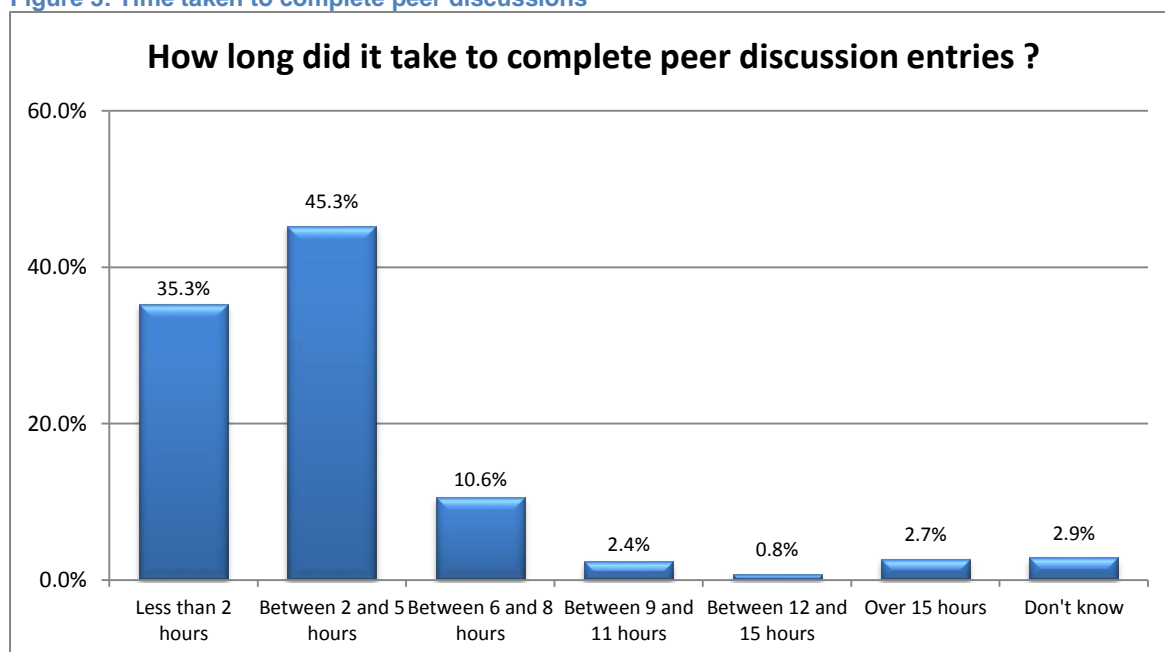
**Figure 2: Time taken to complete planned and unplanned learning entries in the CFtP system compared with the CPD system**



Source: SPH online survey, questions 35 and 38

**The time it took to complete a peer discussion**, including time taken to identify a peer, to make arrangements for the discussion, prepare for and hold the discussion, write up the entry in the CFtP system etc.(Question 46), is shown in Figure 3 below. 16.5% of respondents reported that the time taken was 6 hours and over.

**Figure 3: Time taken to complete peer discussions**



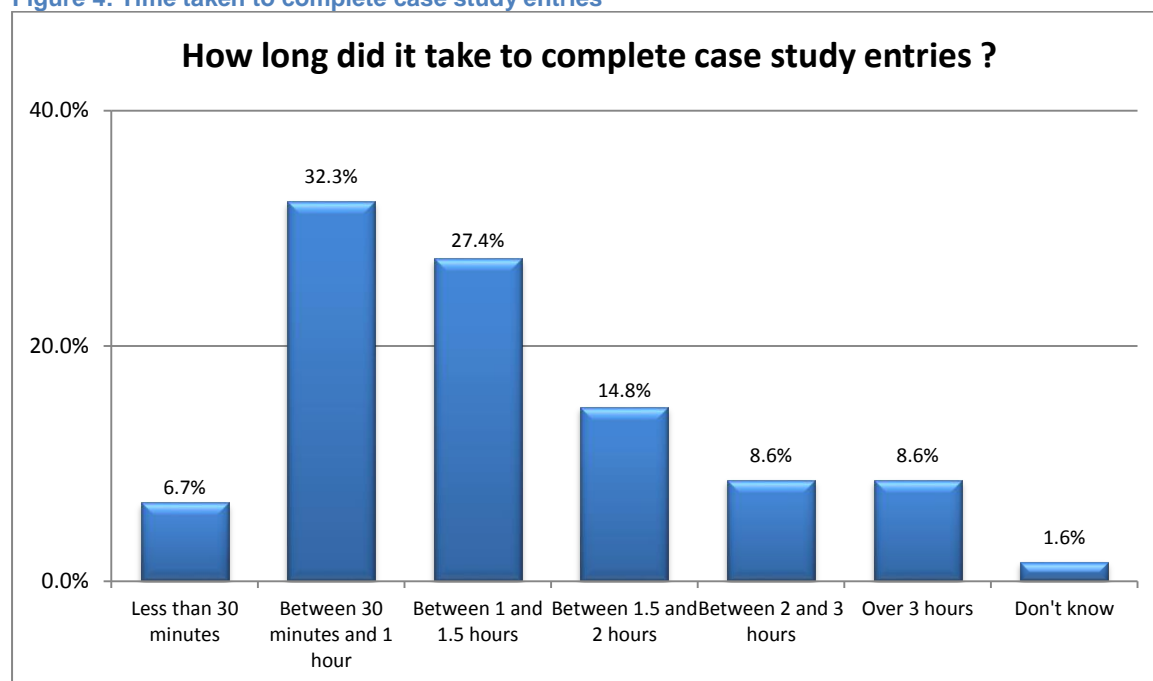
Source: SPH online survey, question 46

Within this, 21.4 percent reported that the discussion itself took less than 30 minutes (Question 47). For 44.6% of respondents the discussion took between 30 minutes and an

hour. 20.4% stated that it took between 1 and 1 ½ hours, and 5% stated they took over 2 hours.

Respondents were asked **how long it took to complete their case study entries**, including the time taken to reflect on what to include (Question 53). The results are shown in Figure 4 below. This shows that most commonly, for 32.3% of respondents, this took between 30 minutes and 1 hour. For 17.2% of respondents, it took over 2 hours.

**Figure 4: Time taken to complete case study entries**



Source: SPH online survey, question 53

Table 6 below combines key elements of these results. It first shows the minimum times reported for each of the types of entry, and adds together the total time for all entries these represent, to give a minimum time it may take overall if six entries made, all of which are completed in the shortest time.

It also shows the most commonly reported times for each type of entry, together with the total times for these. These are shown as a range, based on the shortest reported time for that entry type and the longest reported time for that entry type.

Lastly the maximum times reported for each entry type are shown, together with the total for all elements.

This shows that when added together, the minimum time all entries will take to complete is under 4 hours 30 minutes. The most commonly reported times would range from 4 hours 30 minutes to 8 hours. The maximum time respondents reported taking to complete entries when added together is over 21 hours, assuming that they take the maximum time for all six entries.

**Table 6: Time taken to complete all entry types**

	Minimum times reported		Times most commonly reported		Maximum times reported	
	Time	% of respondents	Time	% of respondents	Time	% of respondents
Planned learning	Under 30 minutes each	33%	30 minutes to 1 hour	44%	over 2 hours	6%
Unplanned learning	Under 30 minutes each	25%	30 minutes to 1 hour	44%	over 2 hours	4%
Peer discussion	Under 2 hours	35%	2-5 hours	45%	over 15 hours	3%
Case study	Under 30 minutes	7%	30 minutes to 1 hour	33%	over 3 hours	9%
Total time for all elements	Under 4 hours 30 minutes*		4 hours, 30 minutes (minimum)* 9 hours (maximum)*		over 21 hours*	

\* based on 6 entries

Source: SPH online survey

The question, **“Approximately how long, on average, did it take you to complete each of your planned learning entries (including time taken to reflect on what to include)?”** (Question 34) was analysed by characteristic. Some differences were seen by setting, as shown in Table 7 below.

**Table 7: Percentages of responses by setting, Question 34**

Approximately how long, on average, did it take you to complete each of your planned learning entries (including time taken to reflect on what to include)?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than one setting	Multiple community pharmacy	Other	Primary care / GP practice
Less than 30 minutes	26%	50%	25%	21%	33%	17%	29%	24%
Between 30 minutes and 1 hour	51%	35%	47%	33%	39%	49%	29%	43%
Between 1 hour and 1.5 hours	18%	15%	18%	26%	14%	25%	21%	15%
Between 1.5 and 2 hours	3%	0%	5%	7%	3%	6%	21%	9%
Over 2 hours	3%	0%	4%	14%	11%	2%	0%	9%
Number of respondents	39	26	118	58	79	140	14	79

Source: SPH online survey

When looking by ethnic group, 72% (of 424) of British respondents had completed their planned learning entries in less than an hour. This figure was 52% (of 42) for Indian respondents, 55% (of 11) for those whose ethnicity was not stated and 55% (of 72) for those in ‘Other’ ethnic groups.

Similarly, the question **“Approximately how long, on average, did it take you to complete each of your unplanned learning entries (including time taken to reflect on what to include)?”** (Question 37) was analysed by characteristic, and variability was again shown by setting, as shown in Table 8 below.

**Table 8: Percentages of responses by setting, Question 37**

Approximately how long, on average, did it take you to complete each of your unplanned learning entries in the CFtP system (including time taken to reflect on what to include)?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than one setting	Multiple community pharmacy	Other	Primary care / GP practice
Less than 30 minutes	33%	56%	34%	26%	38%	26%	29%	35%
Between 30 minutes and 1 hour	50%	40%	46%	38%	37%	51%	50%	40%
Between 1 hour and 1.5 hours	14%	4%	18%	16%	14%	15%	7%	12%
Between 1.5 and 2 hours	0%	0%	2%	7%	5%	7%	14%	9%
Over 2 hours	3%	0%	1%	14%	5%	1%	0%	5%
<i>Number of respondents</i>	36	25	114	58	78	136	14	78

Source: SPH online survey

Other findings of interest were that 11% (of 47) locums completed their entries in over 2 hours, against 3% (of 493) non locums.

When looking by ethnic group, 80% (of 463) of respondents who self-identified as British had completed their unplanned learning entries in less than an hour. This figure was 66% (of 40) for Indian respondents, 55% (of 9) for those whose ethnicity was not stated and 69% (of 80) for those in 'Other' ethnic groups.

The same analysis was carried out for the question **“Approximately how long did it take you to complete your peer discussion (including for example time taken to identify a peer, make arrangements for the discussion, prepare for and hold the discussion)? (Question 46)”**

A greater degree of variability was found between groups when completing their peer discussions than was the case for planned and unplanned entries. This may reflect differences in familiarity with this way of working between different groups. Another possible reason is that different groups find the process of arranging the discussions more or less time consuming than others. For a number of pharmacy professionals the whole peer discussion process took a significant amount of time, in some cases over 15 hours. This is a significant impact and likely to act as a barrier to participation. A detailed picture is therefore presented here in Tables 9-15, to allow the GPhC to identify particular groups they may need to target specific communication towards, both for participants and peers, or other support such as training, to help manage the time taken by peer discussions.

**Table 9: Percentages of responses by role, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>		
	Pharmacist	Pharmacy Technician
Less than 2 hours	33%	47%
Between 2 and 5 hours	46%	40%
Between 6 and 8 hours	12%	4%
Between 9 and 11 hours	3%	1%
Between 12 and 15 hours	1%	0%
Over 15 hours	3%	3%
Don't know	3%	5%
<i>Number of respondents</i>	<i>430</i>	<i>78</i>

Source: SPH online survey

**Table 10: Percentages of responses by setting, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than 1 setting	Multiple community pharmacy	Other	Primary care / GP practice
Less than 2 hours	32%	33%	44%	27%	38%	32%	31%	36%
Between 2 and 5 hours	57%	46%	44%	46%	36%	49%	8%	48%
Between 6 and 8 hours	8%	8%	6%	15%	17%	9%	31%	11%
Between 9 and 11 hours	3%	0%	5%	4%	1%	2%	8%	0%
Between 12 and 15 hours	0%	0%	0%	2%	1%	0%	8%	1%
Over 15 hours	0%	8%	1%	2%	6%	3%	0%	3%
Don't know	0%	4%	1%	4%	1%	5%	15%	1%
<i>Number of respondents</i>	<i>37</i>	<i>24</i>	<i>108</i>	<i>52</i>	<i>72</i>	<i>128</i>	<i>13</i>	<i>73</i>

Source: SPH online survey

**Table 11: Percentages of responses by gender, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>		
	Female	Male
Less than 2 hours	30%	46%
Between 2 and 5 hours	51%	33%
Between 6 and 8 hours	11%	11%
Between 9 and 11 hours	2%	3%
Between 12 and 15 hours	1%	1%
Over 15 hours	2%	4%
Don't know	3%	2%
<i>Number of respondents</i>	<i>352</i>	<i>155</i>

Source: SPH online survey



**Table 12: Percentages of responses by working pattern, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>		
	Full time	Part time
Less than 2 hours	38%	29%
Between 2 and 5 hours	44%	48%
Between 6 and 8 hours	10%	12%
Between 9 and 11 hours	3%	2%
Between 12 and 15 hours	1%	1%
Over 15 hours	3%	3%
Don't know	3%	4%
<i>Number of respondents</i>	352	155

Source: SPH online survey

**Table 13: Percentages of responses by locum/not locum, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>		
	Not locum	Locum
Less than 2 hours	35%	33%
Between 2 and 5 hours	47%	26%
Between 6 and 8 hours	9%	26%
Between 9 and 11 hours	2%	7%
Between 12 and 15 hours	1%	0%
Over 15 hours	3%	5%
Don't know	3%	5%
<i>Number of respondents</i>	465	43

Source: SPH online survey

**Table 14: Percentages of responses by number of years registered, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>			
	Less than 5 years	Between 5 and 10 years	More than 10 years
Less than 2 hours	38%	42%	33%
Between 2 and 5 hours	24%	40%	49%
Between 6 and 8 hours	20%	8%	10%
Between 9 and 11 hours	4%	1%	2%
Between 12 and 15 hours	0%	1%	1%
Over 15 hours	4%	3%	2%
Don't know	9%	5%	2%
<i>Number of respondents</i>	45	93	370

Source: SPH online survey



**Table 15: Percentages of responses by ethnic group, Question 46**

Approximately how long did it take you to complete your peer discussion?				
	Indian	British	Not stated	Other
Less than 2 hours	44%	36%	18%	32%
Between 2 and 5 hours	41%	47%	45%	39%
Between 6 and 8 hours	3%	10%	18%	15%
Between 9 and 11 hours	3%	2%	9%	1%
Between 12 and 15 hours	3%	0%	0%	3%
Over 15 hours	3%	2%	9%	7%
Don't know	5%	3%	0%	3%
Number of respondents	39	388	11	72

Source: SPH online survey

Lastly, responses to the question “**Approximately how long did it take you to complete your case study entry in the CFtP system** (including time taken to reflect on what to include)? (Question 53) were analysed by characteristic.

Responses to this question also varied to a greater degree than for planned and unplanned entries, although more consistency was seen than was the case for peer discussions.

Differences of note were that 37% of pharmacists completed their case study entries in less than one hour, against a percentage of 51% for pharmacy technicians.

Differences by setting are shown in Table 16 below.

**Table 16: Percentages of responses by setting, Question 46**

Approximately how long did it take you to complete your case study entry?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than 1 setting	Multiple community pharmacy	Other	Primary care / GP practice
Less than 30 minutes	6%	10%	5%	5%	10%	6%	9%	4%
Between 30 minutes and 1 hour	33%	43%	32%	18%	31%	38%	0%	22%
Between 1 and 1.5 hours	39%	24%	32%	33%	23%	21%	18%	22%
Between 1.5 and 2 hours	9%	10%	16%	15%	13%	16%	9%	12%
Between 2 and 3 hours	3%	0%	7%	18%	13%	7%	45%	5%
Over 3 hours	9%	10%	9%	13%	8%	6%	18%	6%
Don't know	0%	5%	0%	0%	2%	5%	0%	0%
Number of respondents	33	21	92	40	61	108	11	92

Source: SPH online survey

While not tabulated here, when reviewing results by gender, 10% of males completed their case study entries in less than 30 minutes, compared with 5% of females. However, 17% of males completed their case studies in 2-3 hours, compared with 5% of women.

21% of locums took less than 30 minutes, against 6% of non-locums.

## 5.2 Review of telephone interview findings

The telephone interviews were used to investigate the time impacts of the proposed CFtP framework, and the opportunity was also taken to ask if any other costs, such as financial or in terms of other resources, were incurred. This was asked particularly of the pharmacy professionals and peers interviewed.

The general view was that the proposed framework did not have a significant time or cost impact, although there were exceptions to this.

Most people acting as peers reported that while they did give their time to take part in these discussions, there were no additional resource or other costs, although one noted that they needed to carry out the discussion out of working hours. Arranging the meetings did not present difficulties, other than for the person who needed to hold the discussion out of working hours.

While the pharmacy professional interviewees said their learning and development activities, as well as time taken to record these, were not significantly different in the pilot compared with the current CPD practice, they mentioned that the new elements (case study and peer discussion) required more thinking, certainly initially, than the planned or unplanned elements. It was felt that once they got used to these concepts it would be as straightforward as the other more familiar elements.

Most pharmacy professionals reported that any additional time for planning for or making arrangements needed for the peer discussion was minimal. The peer discussion itself as reported by peers varied in the amount of time it took. In two cases the peer discussions took place over three sessions, each 15-30 minutes long, one completed the whole peer discussion in half an hour, another in one hour.

Writing up case studies was reported as not taking too long, with participants reporting spending between ten minutes and two hours writing up the case study, with an average somewhere around 45 minutes.

It should be noted that the number of interviewees was small (14 pharmacy professionals and 4 peers) relative to the number completing the online survey (602), and therefore less representative of the full range of participants. This reflects the fact that the core purpose of the interviews is to provide qualitative information giving greater depth than can be obtained via online surveys, whereas the online survey is aimed at obtaining a more comprehensive overview.

### 5.3 Conclusions and Recommendations

Findings shown in sections 5.1 and 5.2 suggest that the perception of pharmacy professionals taking part in the pilot is that overall, time taken to complete planned and unplanned learning entries is less in the CFtP system than the time taken in the CPD system. The minimum number of entries required has also reduced from nine to six. Set against this, the proposed case study and peer discussion elements are reported as taking more time than planned and unplanned learning entries. For peer discussions especially, this time impact can be significant. For employers, it should be noted that there is an impact both from the time needed by pharmacy professionals and peers, should either or both of these be employed.

It should also be noted that within the CPD system, while participants are encouraged to make entries on a regular basis, some choose to make their entries only when called for review by the GPhC, which can lead to their needing to make a large number of entries at one time. The proposed CFtP system however requires annual completion of entries, thereby limiting the potential for this.

The extent to which any additional time taken is because these elements are new, and this time will reduce as pharmacy professionals become more familiar with them, is unknown. The separate analyses on Communications given above demonstrates that some pharmacy



professionals interpreted elements of the guidance given in a different way to that intended, which may also have led to them taking more time to complete these entries.

It is recommended that the GPhC review their communications with the particular aim of supporting pharmacy professionals to spend the appropriate amount of time on each type of entry, particularly case studies and peer discussions. They may wish to consider giving more examples, and from different settings, to clarify expectations and to help pharmacy professionals identify a suitable peer more quickly. Short guidance for pharmacists to give to peers may be helpful, as may explanatory tips within the software. A printable proforma may be found helpful for pharmacy professionals to use to write down notes while carrying out their peer discussion, highlighting key requirements. The GPhC may also wish to set a maximum advised time for these elements, as a guide.

It is also recommended that the GPhC review the results of the time taken to complete the various elements by characteristic in some detail, to then consider different communications with different groups.



## 6 Phone Survey

### 6.1 Methodology

The telephone survey questions were developed with reference to the logic model described earlier in this report. Four tailored sets of questions were designed for pharmacists and pharmacy technicians, individuals who acted as peers, employers/line managers of pharmacy professionals involved in this pilot and pharmacy professionals not involved in the pilot.

The sets of telephone survey questions were tailored to the specific group whilst still holding a degree of consistency with each other. Because it had been agreed at the project planning stage that GPhC would provide SPH researchers with contact details of potential interviewees, the researchers knew that they would be speaking with individuals who had participated in the pilot (other than the individual not involved in the pilot), and that interviewees would therefore have a certain level of knowledge of the pilot, and had agreed to be contacted for a telephone interview.

Questions followed the logic model but were designed to aid flow and depth of conversation. They were aligned with questions asked in the online survey, so as to not replicate these directly, but to explore certain issues in more depth. The interviews were planned to take no more than 45 minutes to complete. Draft questions, including prompts for the interviewer, were developed by the SPH team, shared with the GPhC team for comment, revised accordingly and agreed.

Telephone interviews were carried out in two phases, to allow initial (phase 1) findings to be included in the Interim Report requested by the GPhC.

Following completion of initial interviews, a quality assurance review was carried out and small adjustments were made, with the agreement of the GPhC.

SPH spoke with the following sample:

- 14 pharmacy professionals (pharmacists and pharmacy technicians)
- 4 Peers
- 7 Employers, through 4 interviews, one of which was with 3 representatives from one organisation
- 1 Pharmacy professional not involved in the pilot, for an external perspective

As far as possible, pharmacy professionals interviewed were drawn to represent the range of characteristics such as setting, ethnic group, gender etc.

### 6.2 Findings against Desired Outcomes

#### 6.2.1 Outcome 1: The proposed approach is simple to use

##### Ease of completion - overall

A number of comments were made to the effect that pharmacy professionals found the proposed framework easy to use, and quicker to complete than the current CPD system.

For example, when asked “**Were there any particular things which made it hard (or easy) to complete?**” responses included:



*“It was easy. Felt less daunting than old style CPD. It felt simpler to record – rather than fitting to form did it [making pilot entries] as I went along – maybe partly because it was a pilot.”*

*“The questions being so open made it easier to complete. You can write as little or as much as needed. Questions were succinct - didn't go on pages and pages like the last one. It is less onerous. I used to dread filling in the CPD but CFtP isn't too bad. It is an extension of the learning activity. The other system felt like an additional chore.”*

*“It is a lot easier than the CPD system. The structure of the documentation wasn't dragging out. It gave me an incentive to actually document what I was doing. I had no problems doing it and in fact I was happy to document what I had done. The system didn't act as a disincentive like the old system. With the old system I left it as long as I could but with this I was happy to go in and record what I had done.”*

*“The format and the way the questions were asked made it easier to do. It was very well done and very well thought out. Much easier to write up and less time consuming.”*

### Ease of completion – case study

One respondent noted that the inclusion of the case study made it harder to complete overall.

Most of the pharmacy professionals interviewed said that they understood the purpose of each element although four said that they had to spend quite a bit of time thinking about the new elements, particularly the case study. However once they clarified what they thought was expected they found completing the entries straightforward.

For example, when asked **“What did you understand the purpose of the case study to be?”** most answers demonstrated a good understanding of the aims of the GPhC, although there were exceptions. This mix of responses is demonstrated below:

*“This was the hardest element to find an example for. I had to reflect on what would make a good example to be able to demonstrate all the different elements, from why I used this for learning, what I learnt and how I applied it”*

*“The case study was the opportunity to track things right through and show how you had applied the learning”*

*“I expected it to be a theoretical case study, but found that this was a really flexible way of writing about and sharing how you have implemented something you have learned.”*

*“I went to a GPhC workshop and got an understanding from that. GPhC wanted to collate evidence of each of the standards, and basing in on communication this time. Making distinct how you were evidencing meeting the standards.”*

*“Communication is the key word; something I have done or are doing to make a change which includes communication”*

*“I was unsure of what to do. I'm more familiar with this being related to a particular individual patient so was confused about what it could mean in this context. I read standard 3 and then just went with what I thought. I didn't find the example provided that useful.”*

## Ease of completion – identifying a peer

When asked **“How easy was it for you to identify a peer who was willing to take part in a peer discussion with you?”** the majority replied that it was either very or quite easy, with a small number of exceptions. The following examples demonstrate responses given:

*“Because of the environment I work in it was very easy to find a peer. There are lots of people able and willing to be a peer. It is likely to be harder in other settings especially community.”*

*“It was easy as I approached my boss who is also a pharmacist. I believe it probably would have been difficult otherwise.”*

*“Quite easy as I have been in the profession for a long time and I have a large network.”*

*“Not that easy. I had a couple of people in mind. Arranging time was harder. I often have discussions with colleagues but I wasn’t sure that these would count as a ‘peer discussion’. Now I might not feel the need to set it up as formally - I would feel able to just have the discussion and write it up, and feel that this would have met requirements.”*

## Ease of completion – use of the guidance

All of the pharmacy professionals interviewed said that they had read the guidance provided by the GPhC. Two individuals read it at the beginning and referred to it again as they went through. Three more people referred to it throughout the process or read it a couple of times. One person read it just once at the start, saying that they didn’t want to be “too affected” in their way of doing things.

When asked **whether the guidance was clear**, the majority of pharmacy professionals said that they had found it clear, with one saying:

*“It showed how simplistic it can be to complete, and gave a good benchmark of how much detail was needed”*

Additional comments suggested that although the guidance was clear overall, there were different degrees to which people found the examples relevant. One pharmacist said that they liked the examples and *“probably would not have found the case study and peer interviews without them – they were widely applicable, worked examples”*, whereas another said that more clarity was needed. One individual said:

*“some templates and examples were a bit vague, particularly peer review. It wasn’t descriptive enough, there were no prompts. It was more vague than CPD where you just answered the questions. I wasn’t always sure what to put ...whether I had put enough in.”*

Another acknowledged the difficulty of finding examples that would be relevant to everyone and suggested that you might *“need a regional or local champion who could help you with it.”*

One respondent noted that there were no community pharmacy examples in the peer discussion section and that it would be helpful to have at least one example relating to every sector in each section.





There were also two comments that the guide was quite long and might be off-putting for someone who was very busy.

When asked **whether there was any other way in which the information and examples provided could be improved**, one suggestion was that *“when it goes live it may be helpful to support this with short webinars (5-10 mins) to explain. This would also help put a 'name to the face' of people from GPhC”*.

The pharmacy professional that did not take part in the pilot interviewed said that this proposed framework sounds more productive and should encourage more thought than the current process. They also noted that they would not have a problem finding a case study or identifying a peer.

### 6.2.2 Outcome 2: The proposed approach encourages participation

One important factor in encouraging participation is whether participants felt the process to be of value to them. Interviewees were therefore asked **“Do you feel that the CFtP process is a good use of your time”**. All respondents who answered this question said that it was, and some examples of responses are given below:

*“Yes, very much so.”*

*“It’s a good use of time because the old system would have taken longer. This exercise made me re-focus.”*

*“Yes, especially the peer discussion.”*

*“Yes, definitely. By using it first hand, if they introduce it, I could help people not involved in the pilot. I thoroughly enjoyed using it. .... It helped me understand a bit more about CPD, to take on board more what I was doing rather than just writing things up. I learnt a lot and got a lot from it.”*

Other positive comments included:

*“I expected [the case study] to be a theoretical case study, but found that this was a really flexible way of writing about and sharing how you have implemented something you have learned.”*

*“The case study was the opportunity to track things right through and show how you had applied the learning.”*

*“It’s a lot better. It less time consuming, by being simpler. When I was typing in entries I didn’t have to look at my notes because I was remembering things, so I took on a lot more. It was like having a conversation with someone. It was easier to type up without having to look at my notes.”*

*“Definitely an improvement on the current system, more meaningful and relevant.”*

One aspect some interviewees reported was that because the entries were in a more narrative format, they felt that they were ‘telling a story’. This was more fulfilling and interesting for them, and prompted more reflective thinking. As the process was found to be quicker and more enjoyable, some reported making entries closer to the time of learning than had been the case previously.





## Factors facilitating or hindering participation

Interviews also sought to understand if any factors acted as barriers to participation. As noted above, when asked **if there were any particular things which made it hard (or easy) to complete**, the majority made positive comments to suggest that it was easier to complete than the current CPD system.

Interviewees were asked **“What factors have helped or hindered you in your learning being as reflective as you would like it to be?”** e.g. distractions, environment, interaction with colleagues?” Responses included:

*“The nature of my job as an academic means that it is naturally a reflective profession so I’m lucky to have many colleagues with same way of working”.*

*“I have enough time and space at work to do this”*

*“Nothing got in the way. You do need to give yourself the time and space to reflect... The most time consuming element is the learning activity itself.”*

*“My role is field based and I cover a big geography so I do have time to reflect but I cannot always record as soon as I would like to.”*

*“I am very lucky. My employer is very supportive.”*

*“I’m lucky where I work. We’re open at weekends. If I get a quiet spell I can do this. The new website makes it much easier as it is so much quicker and easier”*

*“In my current job, yes. In my last job in a hospital it was harder - did a lot of running around.”*

*“I’ve been in this particular role for 12 months. I think being new in a role lends itself to being more reflective more of the time. It’s been a help to me, I have been thinking about how I can change my practice and whether I’m doing all I can do. It would be different if I’d been in the role longer - I think in that case, the peer discussion would be even more important as it would make you continue to learn from each other in that way.”*

*“It would be nice to get feedback on my submission just to be sure that what I have done is what is expected”*

Factors which hindered reflection included:

*“Really busy stores”*

*“Being busy”*

*“The change in the pharmacy scene in the last 18 months meant that I have had to be reactive as there has been very little time for meaningful research.”*

Participants were also asked **“Do you feel you were able to complete this pilot process as well as you would have liked?”** as a way of eliciting potential issues not identified elsewhere. All who responded stated that they were able to, although one noted they were not happy with their case study. One comment was:



*"It was very interesting and I always like to do new things. The CPD parts weren't so long winded as they used to be. It was a lot easier and smoother to do. Easier to write up"*

### Problems or issues in recording learning

Interviewees were asked if they had **any particular problems or issues in reporting their planned and unplanned entries**. No issues were mentioned other than technical issues related to the software used. Positive comments included:

*"This was one of the easier things to do because it is similar to what the previous/current CPD asks for."*

*"All went quite smoothly. I was really impressed by how smoothly it went and how easy the website was to use."*

Interviewees were also asked if they had experienced **any problems or issues when writing up their case studies**. Most said they had not, but comments about issues found included:

*"It took time to identify a good example, but I think it will be easier in future now I'm more familiar with what is expected. I will probably make a note of good examples to use as I go along in future."*

*"I probably should have written up more. The format of the template doesn't lend itself to long entries. I will probably use this material for the faculty and would need it to be longer for that"*

*"I don't know if they met the criteria. I tried to follow the examples given. It would be good to have headers in the case study - pointers or guidance as you are going along - a "starter for 10" so you know you have done what you need to - prompts. I think it was ok as I followed the guidance"*

*"I had done the thinking but didn't have time to write it up, but I do have a space I can go to if I wanted to"*

One respondent noted that *"It was fine as had the CPPE learning at lunch exercise.... I did case studies for a diploma in hospital."* However, this suggests that the individual perceived the case study to be a clinical case study, rather than a case study as defined by the GPhC.

Peer discussions are discussed more fully in Section 6.2.8 below.

### Role of employers

Maintaining their GPhC registration is ultimately the personal responsibility of the individual professional. However, the support given by employers does vary, and may have an effect on the ability of the pharmacy professional to complete their recording of learning and development activities (and carry out these activities). This area was explored in the interviews.

On the whole pharmacy professionals who took part in the pilot said that their employers knew that they were taking part in the pilot and were supportive of them doing so. However most said that their employers expected them to be fairly independent in pursuing any such professional requirements.



Most interviewees said that they and their employers view CFtP as an integral part of their role as it is required in order to be able to practise and be effective as pharmacy professionals. A typical response from one pharmacy professional was that his employers are not unsupportive but he is expected to manage this himself; they see CFtP as an individual's professional responsibility.

When asked **“How supportive (or otherwise) is your employer in helping you with CFtP?”** responses included:

*“They are supportive. I think they are aware that I am part of the pilot. We don't particularly discuss – they just expect me to get on with things and manage my time around it. I am expected to be self-motivated and manage my own time”*

*“They are very supportive. We were encouraged to take part in the pilot, and quite a few from our training team are involved.”*

*“There isn't much 1-1 support - you don't get asked.... As a professional you are expected to just get on with it. ... there are opportunities for professional development.... It is up to you to make the most of the opportunities they give and it is assumed you will tell them if there's anything they need to know about”*

*“We have due diligence anyway, and CPD is part of this so they know it has to be done so they are supportive. As my pharmacy manager is a pharmacist they know it has to be done and they have been brilliant. They'll say if you have some spare time then go and do some”*

When asked if interviewees were **able to complete CFtP activities at work in their normal working time**, four said yes. Other responses included:

*“Learning activities are mainly at work. I do active learning on the job/workplace learning. I may do some reading at home but majority of learning is at work.”*

*“Activities yes but the recording was outside of work.”*

*“Activities took place at work but writing up was at home.”*

*“Normally in working time.”*

The support offered by employers in terms of allowing time for learning and development activities was mixed, including some offering protected time, and others expecting CPD to be done outside of work time other than for business related training, but with opportunities available if the individual submitted an appropriate business case. Facilities for learning such as e-learning courses were often available.

All employers reported that pharmacy professionals were expected to write up their CPD entries in their own time, although one noted that they had a facility on their intranet site for employees to write down their CPD.

The pharmacy professionals as well as the employers felt that those who worked in isolation (that is the only professional in a pharmacy or in a rural area) may find it challenging to fully engage in the process.

### 6.2.3 Outcome 3: The proposed approach encourages reflective learning, demonstrates an impact on patients or service users and where appropriate, is reflective of the GPhC Standard 3 - Communicate Effectively

#### Reflective learning - overall

The pharmacy professionals who were interviewed all stated that the proposed approach encourages reflection and described their understanding of reflective learning. Most made the point clearly, that they considered that they had always been reflective in their learning and practice, but thought it was useful to have a CFtP system that encouraged this, and allowed recording of this reflective practice.

Participants also said that they reflected on how to apply the learning but because the pilot took place over a relatively short period of time, it was sometimes difficult to demonstrate the full reflection. Participants said that they reflected on further learning needs, and recording often served as a trigger. It may be beneficial for the GPhC to consider including a prompt in the final system for participants to consider this.

Pharmacy professionals were asked **“To what extent do you feel that your learning and development during this pilot period has been reflective?”** Some noted that it had been reflective, but that this had also been the case with the current CPD system. Others noted that it had, but that this reflection was something they did naturally as part of their working life. Other comments suggested that the proposed framework had prompted more reflection than had been the case previously, for example:

*“I always considered my learning to be reflective, but it made me reflect much more. It seemed to stimulate me more. Rather than just reading or listening to a journal/course, it made me look for catalysts - those ‘lightbulb moments’”.*

*Some respondents noted that while they had previously engaged in reflective learning, the addition of the case study and peer review made a difference, for example:*

*“This sits alongside my current practice quite well. The case study and peer discussion were more reflective, especially the peer discussion - that’s how I learn quite a lot - from peers and seniors - but making it part of this process felt good.”*

*“It was the same as before except for the peer review and case study. The others are the same. I had to think a bit more about what to include.”*

The fact that the system took less time to complete prompted some to have more time for reflection, for example:

*“It has made it easier. It has been a lot quicker to write things up. This has given me more time to actually reflect.”*

#### Reflection on how to apply learning

They were also asked **whether they reflected on how to apply their learning**. All who answered this question said that they had. Comments included:

*“It made me think I need to do my faculty again. It did make me think as I wrote it down. I much prefer the new system - it is easier to do entries ad-hoc.”*



*“Yes, absolutely. I noticed this was different in the new system. In the old system you could say you might do x. You now have to demonstrate how you applied your learning. I did reflect on how to apply my learning but would have done this before anyway.”*

*“Yes, but this was always the case.”*

*“Yes....I found myself challenging my own prejudices. It was slightly disconcerting but I got over that and I have made changes which have had an impact.”*

*“Yes in a way. I tend to write down all I learn. So I have a booklet at work where I make a note of things I've learnt. This has given me a bit more time to maybe think about what I've learnt. On the new system, as I was typing it I was thinking about it as well as just writing it.”*

### Reflection on further learning needs

When asked **“Did you reflect on what further learning needs you may have?”** the majority said that they had. Comments included:

*“Yes. This needs to be part of a cycle, so you are continually reviewing and updating this.”*

*“Often one CPD leads to another.”*

*“If you do a learning activity it can raise further questions about your knowledge and gaps in this. I already did this so there was no change when using the new system.”*

### Reflection on choice of case study

Another question asked was **“How did you select your case study? Were you able to reflect on what experience to use and why it was appropriate?”** Not all had completed a case study, but those who had did reflect on their learning needs and how they could improve their service to patients and/or colleagues, although not all had been able to demonstrate an actual rather than potential impact. Examples of comments include:

*“I read the criteria, then really thought about practice. It was a good chance to actually reflect on where I have made a change to my practice”*

*“I had a CPD session about empathy and adherence which I thought was really interesting, and I decided it would be good to include in the learning set. I did reflect and thought it would make a good case study. It could have a big impact. I did consider the impact on the quality of patient care.”*

*“I wrote about how I'd integrated myself in a new clinical area and set up a change in communication approach with the other team - benefitting patients and the nursing and medical team. Seemed to fit and met all Standard 3 criteria.”*

One comment picked up on the issue of the implications where the pharmacy professional has more than one role, which suggests that the GPhC may need to give this area some further consideration, so that participants do not feel disadvantaged if they perceive that the requirements on them are greater than for those in only one role.

*"I picked one from each of my roles as you are supposed to give evidence from all roles you do. .... I tried to show whole process from reflection through to impact."*

## Reflection – role of peer discussion

All four of the peers interviewed said they felt that their discussion supported reflection.

### 6.2.4 Outcome 4: The proposed approach incurs negligible additional time and other costs

The general view was that the proposed framework did not have a time or cost impact, although there were exceptions to this.

For example, most peers reported that there were no additional time or resource or costs required in relation to the peer discussion, although one said that there were as they had to meet outside of working hours.

While the participants said their learning and development activities, as well as time taken to record these, were no different in the pilot compared with the current CPD practice, they mentioned that the new elements (case study and peer discussion) required more thinking, certainly initially, than the planned or unplanned elements. It was felt that once they got used to these concepts it would be as straightforward as the other more familiar elements.

When asked **if there were any additional time or resource or cost required in relation to the peer discussion** e.g. time prior to, or after, the peer discussion for background/preparation? Most stated that there was not, or that this was minimal, for example:

*"The discussion itself took about 1 hour. It didn't take too much additional time. We used a time we have a regular meeting anyway."*

*"It was more effort in some ways, e.g. more planning, coordinating diaries etc. but the discussion and writing up did not take too long."*

The peer discussion itself as reported by peers varied considerably in the amount of time it took. In two cases the peer discussions took place over three sessions, each 15-30 minutes long, one completed the whole peer discussion in half an hour, another in one hour.

Participants were also asked **how much time it took them to do their case studies**. While the actual learning and development activity could take some considerable amount of time, writing these up as records in the CFtP system was commonly recorded as not too long. The participants reported spending between ten minutes and two hours writing up the case study, with an average somewhere around 45 minutes.

### 6.2.5 Outcome 5: The proposed approach is fair and equitable

Although the pharmacy professionals interviewed were not asked directly about fairness and equity, some mentioned that their type of role was well suited to the new approach, with for example academics noting that peer discussions and reflective practice were their normal practice.





When employers were asked **whether there were any groups of pharmacists who might find the process difficult to complete**, two of the interviewees said they could think of some pharmacists not necessarily within their organisation. They said that those who were geographically isolated may struggle to have peer discussions as they would normally work long hours and the peer discussions would need to be done outside of work.

Another point that came out of interviewing participants is that depending on the roles or sector they work in, some can undertake their learning and development and have peer discussions during work time while others have to do this outside of work.

### 6.2.6 Outcome 6: Participants understand the rationale for and requirements of the proposed approach

The terminology used was well understood, for example participants' understanding of 'reflective learning' was similar to that of the GPhC. A typical response to the question "what does the term 'reflective learning' mean to you" being *"If I've done something, and think 'how did it go? What could I do differently, what else can I learn?' Sparking a thought - what I've learnt and what I could change."* As noted previously, the definition of reflective practice provided by the GPhC is "the critical evaluation of practice and learning to find ways to improve outcomes for patients and service users".

#### Peer discussion – clarity of the task

Participants also understood what they could get from peer discussions that was different from other types of entry, for example:

*"The instant feedback, and interaction, and seeing how other people see things - they can see things you haven't."*

*"Peer discussion was less about knowledge, more about skill or behavior – next time, how could you do this?"*

*"A different perspective and that usually helps to arrive at a better outcome"*

One of the aims of peer discussions, to reduce the potential for professional isolation, was touched upon but not brought up to the extent of the issues raised above.

#### Case study – clarity of the task

When asked **"What did you understand the purpose of the case study to be?"** participants broadly understood the GPhC requirements, although there were some exceptions. For example, some comments received were:

*"I believe a case study is more long-term. It will take some time to make a change which will impact on a colleague or service user."*

*"Communication is the key word; something I have done or are doing to make a change which includes communication."*

*"I was unsure of what to do. I'm more familiar with this being related to a particular individual patient so was confused about what it could mean in this context. I read standard 3 and then just went with what I thought. I didn't find the example provided that useful."*

## Unplanned learning – clarity of the task

Most respondents demonstrate a clear understanding of the objectives of unplanned learning. For example:

*“These are where opportunities turn up, where perhaps you didn’t know what to expect and you pick up something new. for example going to a conference and sitting in a session where you don’t expect to learn anything but you get a surprise, or you get an email update about something and follow the link, then realise you’ve hit on a whole new area. Can be the best way to learn – getting those ‘lightbulb’ moments, learning about things you didn’t even realise you needed to know about.”*

*“The objectives of these in CFtP are to evidence learning that happens without you identifying a need in a planned way.”*

## Planned learning – clarity of the task

A similar picture emerged when participants were asked about **their understanding of the objectives of planned learning entries**, for example:

*“Reflecting on what you want to achieve and planning learning activities to do these, then reflecting on what you have achieved as a result.”*

## Clarity and usefulness of the guidance

All participants said the guidance and the examples were clear and useful, using straightforward language. They mentioned referring to the guidance often.

A couple of participants felt that all the elements should have examples for all settings. One person suggested that the guide is quite long and might put people off. However, adding further information such as more examples would make the guidance longer, therefore the GPhC may wish to investigate ways to balance these two requirements, perhaps by having short initial guidance giving the minimal necessary information, with more detailed information easily accessible and searchable.

Some misunderstandings were apparent, with one interviewee feeling that for the case study they needed to demonstrate a clinical case study. Interviewees also in some cases used the terms ‘peer discussion’ and ‘peer reviews’ interchangeably.

### 6.2.7 Outcome 7: The proposed approach is seen by stakeholders as providing assurance of fitness to practise

Most participants said that they felt the pilot CFtP was robust in providing assurance of pharmacy professionals’ fitness to practise. Some implied that they felt that members of the public would just like to know that they are doing what is required to remain registered and were keeping abreast of necessary knowledge. They felt that the public were probably not interested in the details as long as they were providing a good service.

Pharmacy professionals said that they felt that the proposed framework demonstrated that they were required to keep learning and updating their skills. Three people highlighted the case study and peer discussion as elements that they felt helped provide assurance, and



offered less opportunity to misrepresent learning and development activities. One also said that they felt the planned learning element may be less 'robust':

*"...it shows that people have to do the learning and keep up to date. Peer review aspect helps provide assurance and the case study makes it more 'real'. This should be reassuring to people looking from the outside."*

*"As a whole the process is improved but it is not watertight. The case study and peer discussion have improved the rigour of the system to make it more robust. Am less convinced about planned learning. Not sure how you get round this - how can people provide evidence they have done what they say? It is hard to say if it is robust as don't know what robust is."*

Others were less confident that the system would reassure members of the public:

*"It is hard to say. Members of the public wouldn't know whether what I was learning made me more professional than someone else. It certainly gives assurance that you are keeping learning. The new system is more meaningful so has to give more."*

*"This is not the best way of saying that this person is fit to practice. Would need to look at their job description and see how CPD and their entries fit into that. Annual Appraisal to be integrated with portfolio of practice that we provide to the Royal Pharmaceutical Society. All these elements would all need to be integrated. In this process, you can potentially just write what you want."*

Participants were also asked whether they thought that **the number of entries is appropriate, to give assurance**. Most felt that this number is appropriate, and that while the number has reduced from nine to six, the quality of individual entries has improved. The inclusion of the peer discussion and case study entries was mentioned as having made the system more robust. For example:

*"Yes, especially as you can go into different levels of detail for different entries, and especially as the peer discussion is slightly longer."*

*"Yes. I usually do more but just write all of them up. 6 is perfectly adequate so long as they are meaningful, and can show impact and added value for your patients, especially as they have the 'meatier' case study and peer conversation elements. It is a case of quality over quantity."*

*"Having fewer could prompt people to update it more regularly. I generally update my entries regularly but I work in an environment that supports this. Encouraging people to do it regularly is really important."*

*"The quantity is not significant. The mix is significant. Do you need 2 planned? You should all be doing CPD for your own satisfaction whether you record it or not. The quantity was appropriate in terms of workload. The peer discussion and case study were essential. You can all say we did CPD, and who can tell if you are telling the truth. There is no hiding place with the case study and peer discussion."*

*"Fewer entries that encourage more thought are the way to go."*

When asked whether **the time and effort it takes to complete matches the benefit it gives in providing assurance**, to get an insight into whether the system is proportionate, the general view was that it does, although it was acknowledged that it could be difficult to define a proportionate amount of time and resource. For example:



*“It wasn’t hugely time consuming but if done right it can bring about a change in practice.”*

*“Yes, although don’t know what a member of the public or a patient would expect or think is the right balance.”*

*“Didn’t take too long to do – and it’s important to record it. Overall it’s much better than the old system.”*

*“Yes. If I was a patient I would rather a pharmacist learnt little and often and put it into practice than write whole essays but not do anything with it then yes.”*

*“I am not sure as I don’t feel confident that those pharmacists who didn’t engage will. They probably should be dealt with separately”*

*“The fact that it’s made easy to record, makes it more accessible and do-able. If there was more effort required it wouldn’t lend itself to reflective learning from day to day activities. It didn’t feel onerous.”*

## **6.2.8 Outcome 8: Peer discussions are robust and appropriate**

### **Selection of a peer**

Most of the participants interviewed stated that it was quite easy to find a peer. One of these noted that it may get more difficult going forward when all pharmacy professionals have to complete this element, as their employer would need to make the time available for them all to have these discussions. Another person noted that they had not had a peer discussion, as they planned to hold this with their line manager, but that individual went on maternity leave and their replacement was not settled enough into the role to do this in the time available. A further respondent who had difficulty reported:

*“I often have discussions with colleagues but wasn’t sure that these would count as a ‘peer discussion’.”*

Most said that their peer was another pharmacy professional, and in two cases said that this was their line manager.

In the case of one person who had a positive experience of peer discussion, it was clear that they had carefully selected their peer:

*“I chose a colleague who has just completed an MSc in education so has good knowledge of peer education/discussion, and knows how to frame feedback. Often pharmacy professionals are not taught how to give feedback.”*

The latter comment suggests that a short summary for pharmacy professionals to be able to provide to peers, describing the role as well as how to give constructive feedback may be helpful.

One of the participants interviewed stated that their peer was from another health care profession and that this was a deliberate choice as they would find it difficult to identify someone with whom they had a sufficiently positive relationship.

Another commented that the discussion had gone well:



*“possibly because we were not reporting to each other (different line managers) we were able to have a full and open discussion as colleagues.”*

One difficulty reported was that of finding a peer who may already be aware of the proposed changes to CFtP. However, the intention of the GPhC is that peers can come from a range of professions and therefore may well not be aware of CFtP. That participants see this as a barrier suggests that they have not fully appreciated that their peer does not need to be a fellow pharmacy professional.

When asked **whether the meeting was just to cover the CFtP discussion or part of a wider meeting, such as a regular 1:1**, seven participants said they had arranged the meeting specifically for a peer discussion as part of the CFtP pilot. Of the remainder, one person included the peer discussion as part of a wider 1:1, saying *“We have regular, ongoing discussions, and this fitted well into one of these.”* Another used an existing (regular) meeting topic, and said *“We have been having ongoing discussions about how to make the visits to the care home work as best they can, and these were used for the peer discussion.”*

### Openness of the discussion

Most appeared to choose a peer they were comfortable with and therefore it is difficult to determine the objectivity of the relationships with the peers chosen. When asked **whether they were able to have a full and frank discussion**, one individual said:

*“Yes. She is a very frank and honest person. She dragged out the good bits of my practice and addressed the poor.”*

*“Yes. We are good colleagues. I would instinctively go for someone you already have a good relationship with. I would have no problem identifying a new topic every year.”*

Many participants used the peer discussion as one to bounce off ideas relating to their work with a colleague and found the discussion very useful.

There was only one individual who disagreed that they had experienced a full and open discussion, saying *“It didn't feel full and open - it was just ticking a box”*.

### Clarity of the peer role

Participants said that they found it easy to explain the role of the peer, and that in many cases this was not necessary as the peer was also taking part in the pilot. However interviews with a few of the peers suggest that each peer had a different understanding of their role. One peer discussion sounded more like a teaching session while another saw her role as that of a mentor. As noted previously, the provision of short guidance notes for peers may be helpful.

When asked **whether they would be prepared to act as a peer in the future** all the participants said, quite enthusiastically, that they would, seeing this as a two way process. The one negative that could be associated with the role would be time.

Each of the four peers interviewed began the process with different levels of knowledge of the pilot process:

*“I assumed it was a mentoring role after having a conversation with my colleague who approached me.”*

*“Yes, the pharmacist explained what was required. They were my only source of information, and that was fine.”*



*“Yes, from previous experience, from what I knew already and what my colleague told me.”*

*“Yes, because I am taking part in the pilot I knew what was expected of me.”*

For all but the peer who was themselves participating in the pilot, their main source of information was the pharmacy professional for whom they were being asked to act as peer. This may be an issue the GPhC wishes to consider when planning its future communications strategies.

### Method of peer discussion

Most of peer discussions were face-to-face, and in three instances they were by telephone or a combination of face-to-face and telephone. Most found their chosen method of face-to-face or telephone appropriate or beneficial. For example, one person, who had a face-to-face peer discussion said:

*“I could see the body language which is always very helpful but at the same time a peer discussion should be professional and not become a social meeting.”*

Another individual who had their peer discussion by telephone said *“I often speak about work matters with this person by phone, so felt quite comfortable.”*

### 6.2.9 Outcome 9: Each element of CFtP meets its’ objectives

When asked **whether they had made any changes to their practice as a result of their planned learning**, all participants who responded said that they had. One person responded that this was based largely on mandatory training.

Participants were also asked **whether they had made any changes to their practice as a result of their unplanned learning**. Again, the majority replied that they had. One person who said that they had not did note that:

*“No changes to practice, but I now know what to do in that clinical scenario/ condition, and wouldn’t need to look it up or ask someone”.*

One person stated *“Not really, this is about knowledge rather than changing practice”* suggesting that they were not clear about the GPhC’s expectations.

One of the participants who said that they had made changes to their practice commented that in addition they had identified other benefits:

*“My attitude has changed. I’m now more receptive to learning and to documentation.”*

A question which sought to establish if participants had been able to demonstrate making a change to practice which would improve their service to patients or colleagues was **“Did you make any changes to practice as a result of doing the [topic/subject you used as a ] case study?”** The majority replied that they had, and were largely positive about this element of CFtP. For example:

*“We implemented some changes and now have better communication with the practice, which helps patients, and helps the GP, GP staff and pharmacy staff make better use of their time.”*



*“It was good to do. I think it met the purposes. I went back to the sample entry to check, and that was helpful.”*

Participants felt that the peer discussions met their overall objectives, however it is not possible to assess this as the discussion is confidential. Benefits reported by those acting as peers included:

*“Learning that peer support can be up and down the ladder, rather than just across.”*

*“I felt we moved the service development forward.”*

The employers interviewed said that they would probably not see day to day changes in practice as a result of learning but this may be picked up during pharmacists’ appraisal. One employer mentioned that they picked up on the fact that the pilot encouraged reflection during a peer discussion.

### 6.2.10 Outcome 10: Any unexpected consequences are identified

Few unexpected consequences were identified from the phone interviews although the comment was made that as it was a pilot, people did not know what to expect.

One person reported being pleasantly surprised to find that they were enjoying the process, and felt much more motivated to complete their CFtP entries than was the case with the current CPD system. Others echoed this point, saying that they had thoroughly enjoyed being part of the pilot. Particular comments included:

*“I realised that with the old system I hated completing it, so when I did some kind of CPD activity I felt guilty because I should have been recording it but didn't want to. Once I started using the new system it was so much easier. I was quite chuffed with myself.”*

*“I’m a lot more aware that it’s OK to have peer discussions and I’m more supportive of them.”*

*“I was surprised - I was a bit worried at first not knowing what to expect, but it was very easy to do and I was surprised at how well organised it was.”*

### Comparison with the current CPD process

When asked **“How does it compare with the CPD system in terms of helping you improve your practice and improve outcomes for patients/ service users?”** responses included:

*“Having the peer review and case study is good to make you think about things in a different way.”*

*“I thought about it a lot more. Just the change of name to CFtP changes the mindset, and makes it feel more meaningful. It felt less like a chore that just has to be done. It feels more enjoyable.”*

*“The difference is in the way of recording – more flexible, more timely.”*



*"It was much more meaningful. The other was so onerous so would select easier learning opportunities to reflect - I'd just think I'll just put in this little thing because it will be the easiest to write up. There were so many boxes to complete and didn't have to show how you actually put learning into practice. Now I think I'll think a bit more carefully about which learning opportunities to reflect and what to put in that is meaningful, and shows that you've added value, and have benefit for patients or service users. It's definitely a better system - makes you think at a deeper level"*

*"It is way better this may be because I am relatively newly qualified"*

*"I saw the CPD recording in the old system as a necessity and hated every minute of the recording. The pilot felt quite stimulating, which was a massive sea change. I am getting close to retirement and for a few years have been working well within my comfort zone. The new process kicked me up the backside to get out and achieve more."*

*"This is more about other people than about you. CPD was more about what you did whereas the Case Study and Peer Discussion are about what you learned that can help others which is the focus of the NHS - what you can do for others, what value you add."*

When asked if they wanted to add anything else, one respondent said *"I really liked the new system and hope it's here to stay."*

### 6.3 Conclusions and Recommendations

The approach used in the pilot appears easy to understand and use. The pilot participants felt that they understood the purpose of each element although they referred to the guidance a number of times to be sure they were doing what was expected of them. They commented that they found the guidance generally very clear although they found the examples relevant to varying degrees. Requests were made for more examples to be provided in different settings.

About a quarter of the interviewees said that they spent a lot more time thinking about the new elements of the proposed framework, that is the case study and the peer discussion. However, once they felt they had clarity they found the entries straightforward. Over 80% of the study participants stated that it was quite easy to find a peer, most of the peers were healthcare professionals and all felt that the peer discussion encouraged reflection. All found the planned and unplanned learning fairly straight forward.

On the whole the pharmacy professionals who took part in the pilot said that their employers were supportive but expected them to carry out such professional requirements independently.

Both employees and employers view CFtP as an integral part of the role of pharmacy professionals as this is required to be able to practice.

The interviews carried out suggest that the pilot did not lead to any changes in terms of when and where pharmacy professionals undertake their learning or complete their CPD entries, in terms of whether they completed them in work time and/or their place of work, although some reported completing their entries closer to the time of the learning activity.

All interviewees said they would be happy to act as peers in the future.





One interviewee highlighted the fact that working in isolation (as the only pharmacy professional in a pharmacy most of the time particularly in a rural area) is a potential barrier to engaging in the CFtP process. This could potentially lead to an equity issue.

The pharmacy professionals interviewed felt that the proposed approach encourages reflection as well as action. Many point out that they have always been reflective in their practice as this is the nature of the profession but it would be useful to have a framework that allows professionals to demonstrate this.

All the pharmacy professionals felt that the number of entries was appropriate in terms of the system being robust, with a number noting that the quality rather than the quantity of entries was key.

The pilot participants generally did not feel that there was an increased time and cost impact as a result of this proposed approach although a number of the peer discussions took place outside of work.

The principle unexpected consequences reported were that some participants found the proposed framework much more rewarding and enjoyable to complete, prompting more reflective thinking and encouraging them to make entries closer to the time of learning activities. There were a number of positive remarks about the proposed process.

The suggestion was made that prompts are included in the system. These could appear at relevant points to remind people of the key requirements of a particular section. Another option may be to make the questions asked slightly longer to include relevant points. It was also suggested that the ability to access information such as the GPhC Standards directly within the system is added.

## 7 Online Survey

### 7.1 Methodology

An online survey was administered using SurveyMonkey, with the link to the survey being sent to all those who had volunteered to be part of the pilot by GPhC via email.

The online survey questions (listed in Appendix 5) were developed with reference to the logic model described previously to determine the appropriate question areas. The overall process is described in Figure 5 below.

Figure 5: Online survey process



**The complete set of analysis and all the free text responses have been provided to GPhC.**

Not all questions were answered by all respondents, and some questions were relevant only to a subset of respondents (for example, those who stated that they worked part time were asked if this affected their ability to complete the pilot, but those who stated that they worked full time were not asked this question). In the analyses presented below, where the percentage(s) of respondents selecting particular answers are shown, these percentages relate to total number of people answering that question, rather than to the total number of people completing the survey, unless otherwise stated.

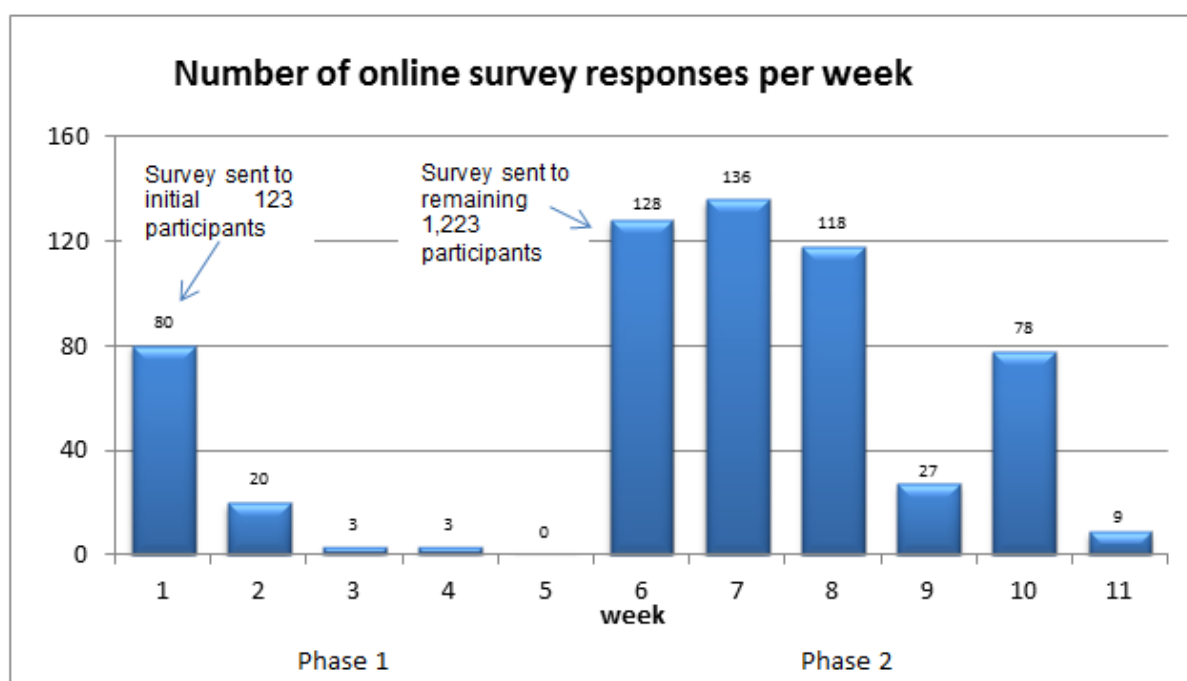


## 7.2 Key Findings

By the end of the pilot period (31<sup>st</sup> December 2016), 894 of the 1,346 pharmacy professionals who had volunteered to be a part of the pilot had made entries to the pilot system. 602 of these completed the online survey (67% of 894, and 45% of 1,346).

Figure 6 below shows the spread of responses. Overall, the response rate was 45% (602 completed surveys received from 1,346 pilot participants). Within this, as part of Phase 1, 123 participants who had completed the six required entries by mid-October were asked to complete the survey, and 106 (86%) did so. As part of Phase 2, the remaining 1,223 participants were asked to complete the survey, and 479 (39%) did so.

**Figure 6: Number of online survey responses per week**



Source: SPH online survey

The characteristics of those responding to the survey are shown in Table 17 below. This also shows the characteristics of the cohort of people who signed up to take part in the pilot, for comparison.

**Table 17: Characteristics of survey respondents**

Number of survey respondents			Number who signed up to participate in the pilot		Difference in percentage between those who signed up to participate and survey respondents
602			1,346		
<b>Roles:</b>					
Pharmacists	501	83%	1045	78%	6%
Pharmacy Technicians	98	16%	301	22%	-6%
Not stated	3	0%	0	0%	0%
<b>Settings:</b>					
Academic / educational	42	7%	111	8%	-1%
Hospital	129	21%	333	25%	-3%
Independent community pharmacy	60	10%	189	14%	-4%
Multiple community pharmacy	153	25%	401	30%	-4%
Primary care / GP practice	83	14%	169	13%	1%
Advisory / regulatory	29	5%	66	5%	0%
Other setting	17	3%	77	6%	-3%
Mix of settings	85	14%			
Not stated	4	1%			
<b>Country:</b>					
England	462	77%	1062	79%	-2%
Scotland	30	5%	211	16%	-11%
Wales	105	17%	73	5%	12%
Not stated	5	1%	0	0%	1%
<b>Gender:</b>					
Female	417	69%	933	69%	0%
Male	180	30%	412	31%	-1%
Not stated	5	1%	1	0%	1%
<b>Full time / part time:</b>					
Full time	425	71%	982	73%	-2%
Part time	173	29%	303	23%	6%
Not stated	4	1%	61	5%	-4%
<b>Locum:</b>					
Yes	55	9%	70	5%	4%
No	544	90%	1276	95%	-4%
Not stated	3	0%	0	0%	0%
<b>Number of years Registered:</b>					
Less than 5 years	50	8%			
Between 5 and 10 years	118	20%			
More than 10 years	428	71%			
Not stated	6	1%			
<b>Ethnicity:</b>					
British	454	75%	975	72%	3%
Indian	46	8%	130	10%	-2%
Other	85	14%	203	15%	-1%
Not stated	17	3%	38	3%	0%
<b>Disability:</b>					
Yes	6	1%	23	2%	-1%
No	584	97%	1306	97%	0%
Not stated	12	2%	0	0%	2%

Source: SPH online survey

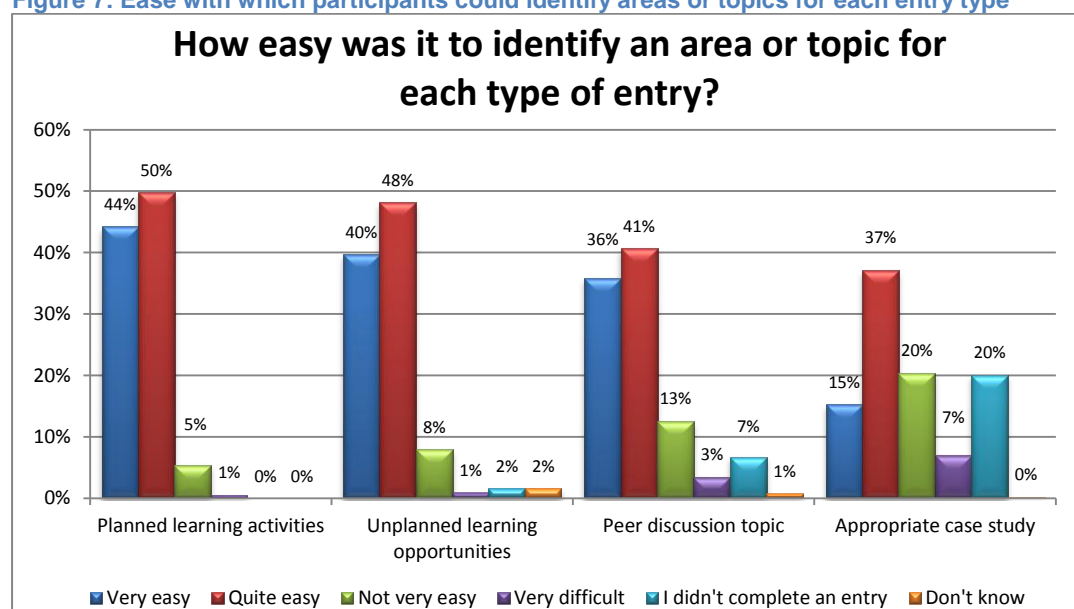
## 7.3 Findings against Desired Outcomes

### 7.3.1 Outcome 1: The proposed approach is simple to use

The key initial phase of CPD or CFtP is to be able to identify opportunities for learning and development. A number of questions in the online survey were aimed at establishing **whether participants were able to identify areas or topics for each type of entry**, and where they did, how easy this was (Questions 33, 36, 40, 42, 49 and 50). Figure 7 below demonstrates the results of these.

As might be expected, because participants are more familiar with planned and unplanned entries, 94.1% of respondents found it either very or quite easy to identify planned learning activities, and 87.9% found it very or quite easy to identify unplanned learning opportunities. In contrast, 76.5% of survey respondents found it very or quite easy to identify a topic for a peer discussion, with 6.7% not completing a peer discussion entry. 52.4% found it very or quite easy to identify an appropriate case study, with 20% of respondents not completing a case study.

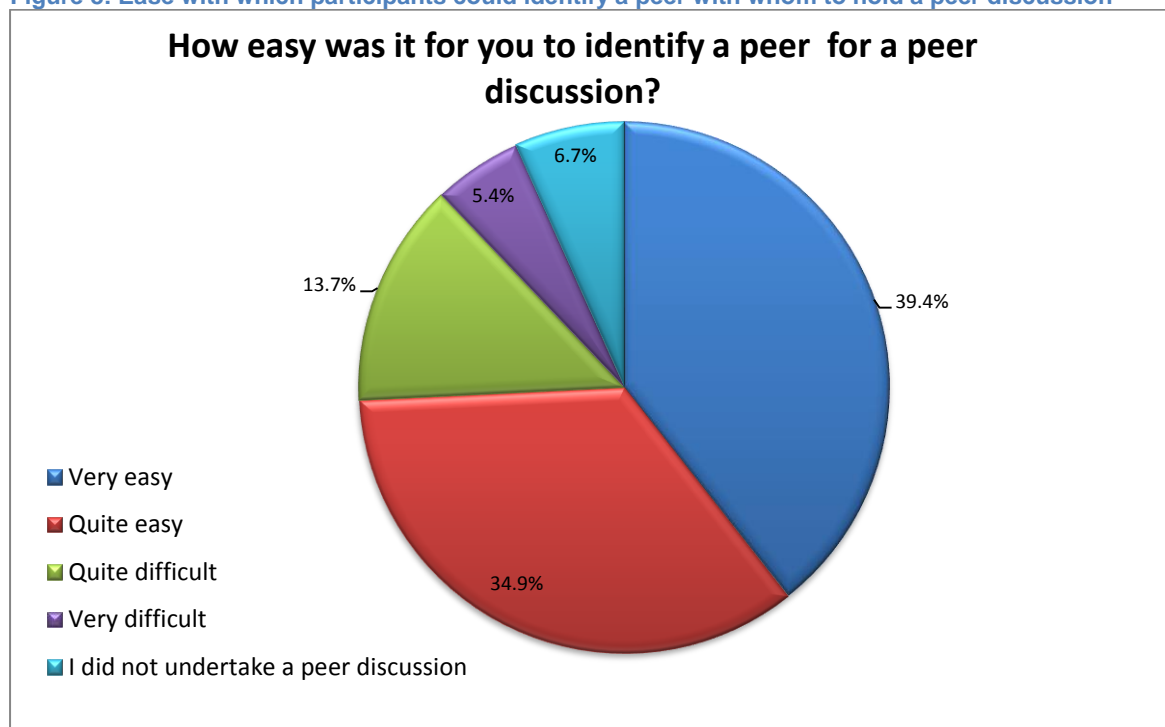
Figure 7: Ease with which participants could identify areas or topics for each entry type



Source: SPH online survey, questions 33, 36, 40, 42, 49 & 50

For the framework to be easy to use, it is important that pharmacy professionals are able to identify a peer with whom to hold a peer discussion. Participants were asked **how easy it was for them to identify a peer who was willing to hold a peer discussion with them** (Question 40). As shown below in Figure 8, while 74.3% of respondents found it quite or very easy to find a peer, 19.1% found it quite or very difficult, and 6.7% of respondents did not hold a peer discussion.

Figure 8: Ease with which participants could identify a peer with whom to hold a peer discussion



Source: SPH online survey, question 40

Comments made giving additional insight to this question included:

*"I ran out of time"*

*"Some pharmacists are reluctant to be named [as a peer]"*

*"It was easy to identify someone but difficult to arrange time with them"*

*"I think 'peer' can mean different things to different people and in different contexts"*

*"I work alone and had no opportunity"*

*"Found it was a false situation rather than a genuine opportunity"*

*"I am afraid I did not really consider this as I have to do all of my CPD learning in my own time due to work pressure (something I think is fairly widespread). If I had asked a colleague again it would have been in their own time so I was a little reluctant to do this. If it became mandatory it would be a quid pro quo situation as we would all have to help each other?"*

*"Unable to find a suitable peer"*

*"I changed job role in May and it wasn't easy. Going forward...it would likely be easier"*

One respondent cited difficulty in knowing who to put down as the peer as it was a group discussion, although instructions for this were provided in the guidance.

*"I work across several teams and have 3 distinct roles. Hence I was unable to find someone who had the time or experience to help support my CFtP entries"*

The majority of respondents (74.0%) carried out their peer discussions face-to-face (Question 43), with 10.7% holding them as a group discussion, 9.8% holding them over the phone, 0.6% holding them as a video call and 4.9% stating they used 'Other' methods. Within this category, 13 respondents stated that they had used a mix of methods. In some cases, this was because the discussion became ongoing.

The majority of respondents (92.4%) said that the method they had used worked either very well or quite well (Question 45). Of those who said it worked very well or well, 27% held their peer discussion face-to-face, 11% as a group discussion, 9% over the phone and 1 person as a video call. 19% used other methods. These were generally a mix of the other methods, although one used skype as they were out of the country. 4.1% (20 individuals) stated it did not work well. Of these, 10 were face-to-face, 2 were a group discussion, 5 were over the phone and 2 were video calls, and 1 was 'other'. 0.8% felt it had worked very poorly. 75% of these were held face-to-face with the remainder over the phone, 2.7% responded "Don't know".

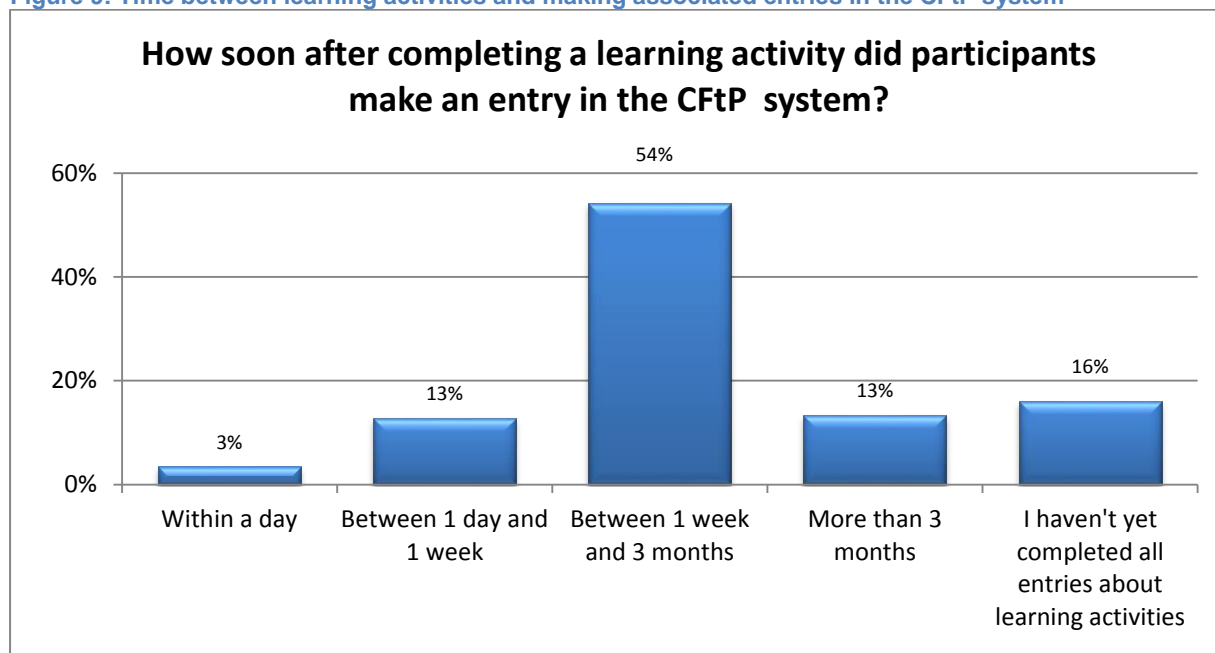
### 7.3.2 Outcome 2: The proposed approach encourages participation

A fundamental building block to participation is how important pharmacy professionals think learning and development is. If it is not considered to be important, individuals are less likely to prioritise making entries to the CPD or CFtP system. When asked the question **"How important do you think learning and development is to your role?"** (Question 12) 84.0% of respondents answered "Essential", 13.5% answered "Very important" and 2.1% answered "Quite important".

The GPhC is keen to encourage pharmacy professionals to record their learning activities as soon as possible after the learning has occurred. Survey respondents were asked **how soon after completing a learning activity they usually made associated entries to the CDP or CFtP systems** (Questions 15 and 18). Figures 9 and 10 below shows that participants made entries to the CFtP system sooner after the learning event than was the case in the current CPD system.

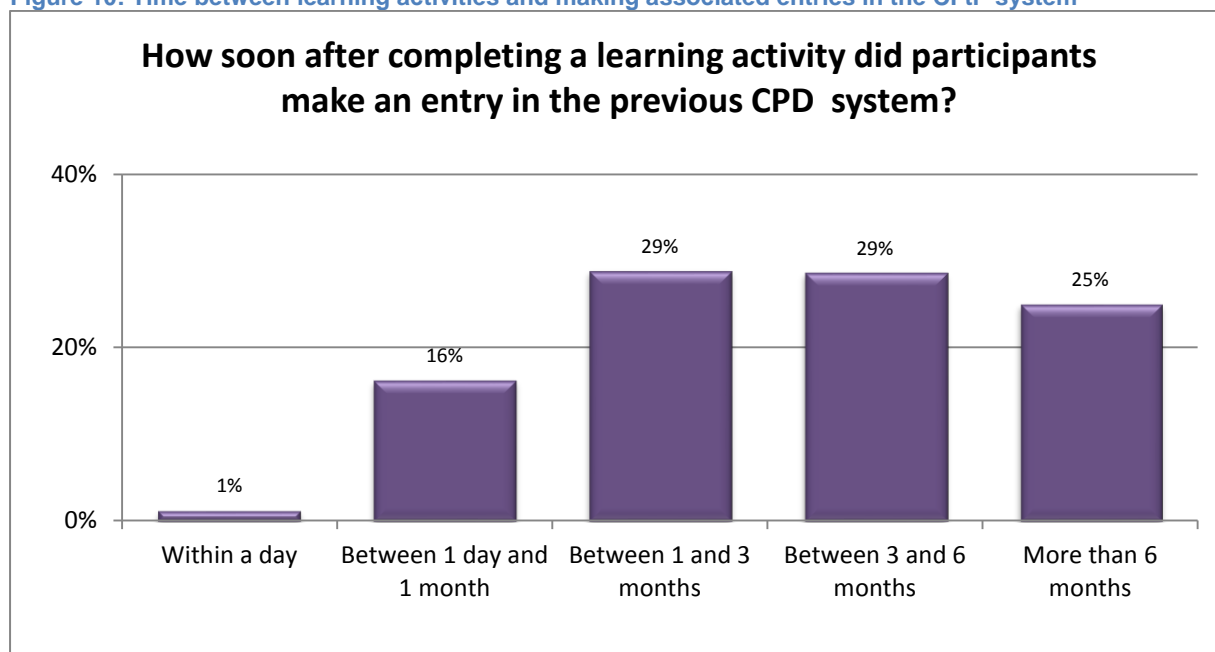
In particular, 71% reported completing their entries about a learning activity on average within 3 months of the activity itself in the CFtP system, compared with 46% in the current CPD system. While this may be because participants were able to make entries into the pilot system only during the limited period over which the pilot was open (April to December rather than over a whole year), responses elsewhere do suggest that for some participants, the proposed framework encouraged them to make their entries sooner after the learning activity.

**Figure 9: Time between learning activities and making associated entries in the CFtP system**



Source: SPH online survey, question 15

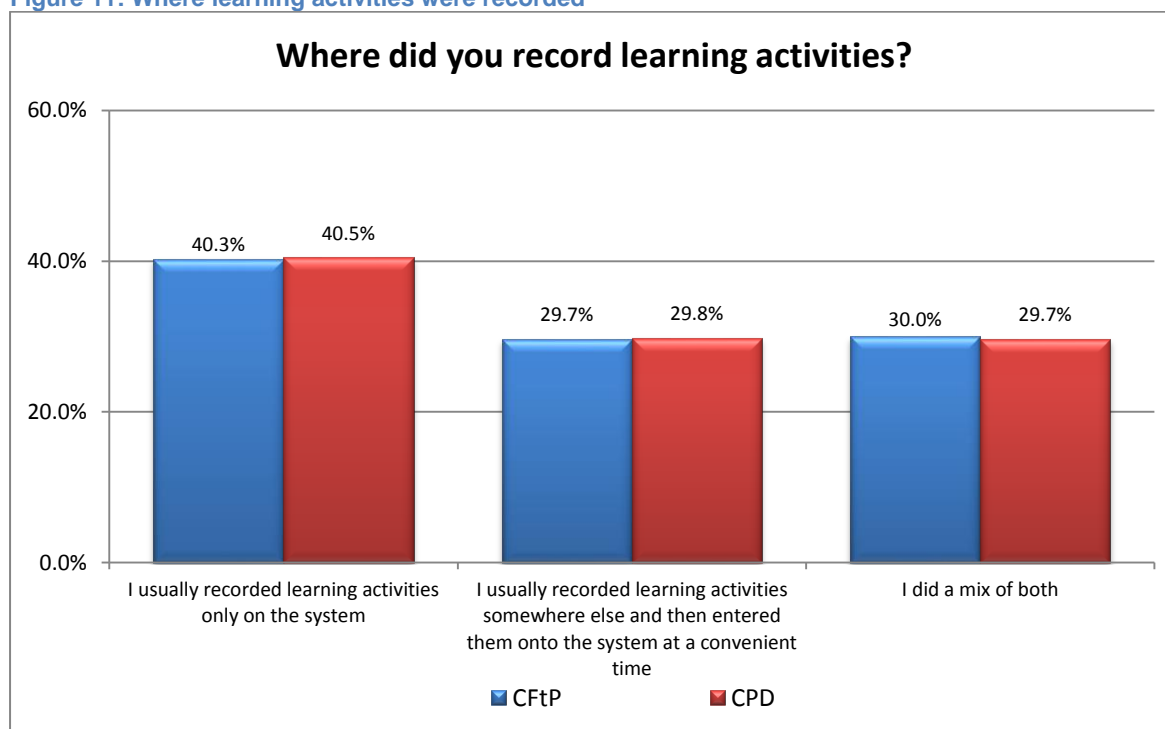
**Figure 10: Time between learning activities and making associated entries in the CFtP system**



Source: SPH online survey, question 18

Respondents were also asked **whether they usually recorded learning activities only on the CPD or CFtP system, or also recorded them separately** (Questions 16 and 19). As shown in Figure 11 below, there was little difference in behaviour between the two frameworks.

Figure 11: Where learning activities were recorded



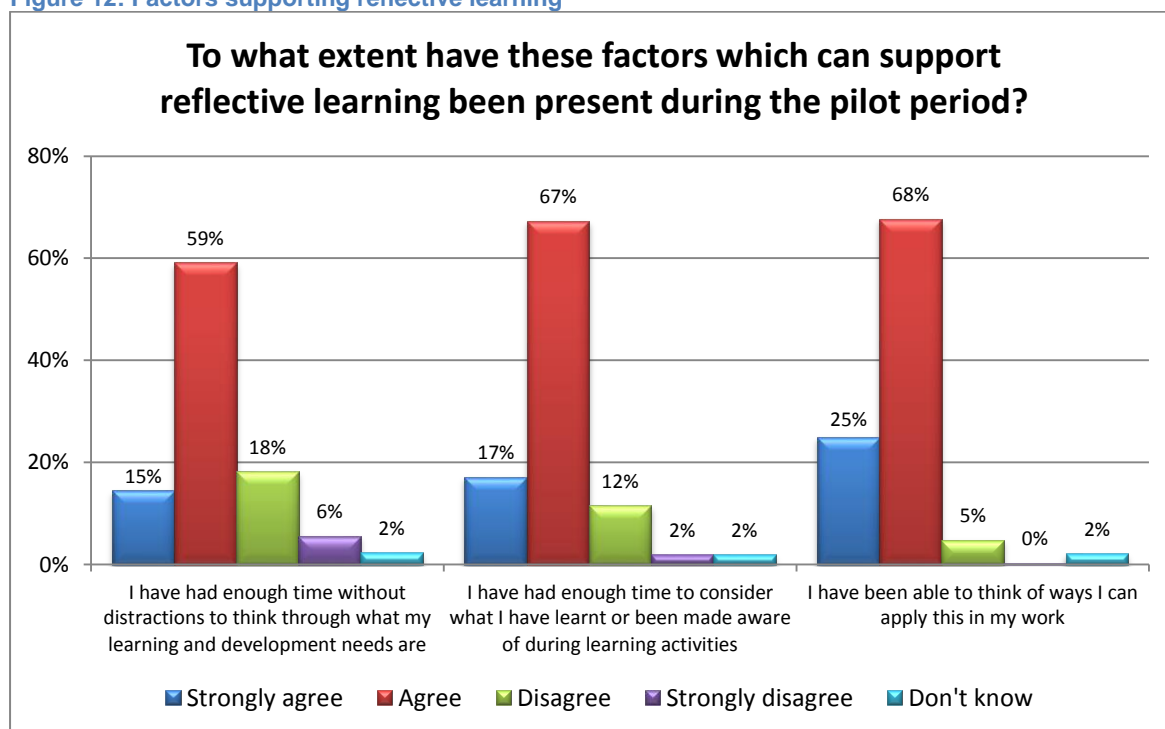
It is unlikely that any system could completely remove the need to sometimes record information about learning elsewhere before recording on the system. However, the quicker and easier a system is to use, the easier it becomes for individuals to record their learning activities just within that system, reducing duplication of effort. One comment received was that it would be helpful to be able to fill in an entry offline (for example, on a train returning from a conference), then upload it later when online. All such functionality may be expected to support increased participation.

63.0% of respondents reported that they entered or updated records to the CFtP system between 2 and 6 times (Question 17). 21.4% did so more than 6 times and 15.6% did once. Entering or updating records more frequently may suggest that this is being done closer to the time of the learning activity (although there will be other reasons).

To maximise potential participation, it is important to identify both supporting factors and barriers, so as to be allow the GPhC to consider possible courses of action to either maintain or increase support or reduce barriers.

Participants were asked about **particular factors which could support reflective learning**, as shown in Figure 12 below. 73.8% agreed that they had had enough time without distractions to think through what their learning and development needs were. 84.6% reported that they had enough time to consider what they had learnt or been made aware of and 92.7% said that they had been able to think of ways they could apply their learning to their work. This shows that respondents had most difficulty in getting time to think through their learning and development needs. This may affect their ability to identify planned learning needs and peer discussion planning in particular, as these are more reliant on this.

Figure 12: Factors supporting reflective learning



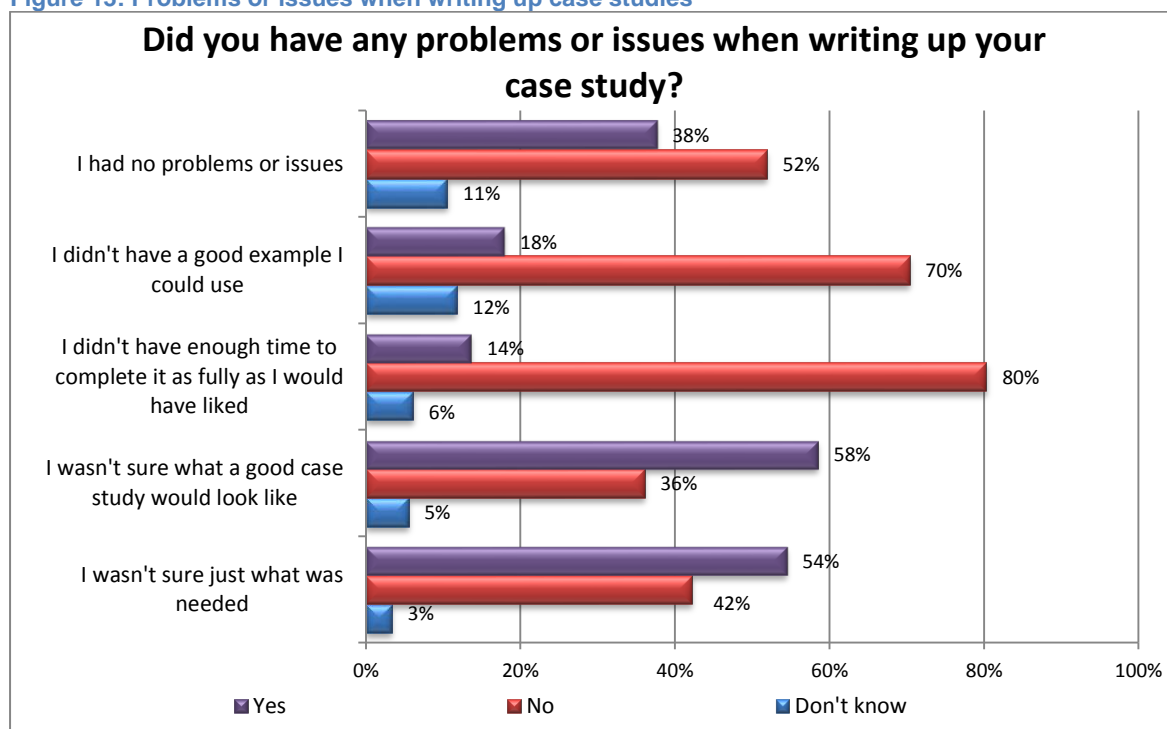
Source: SPH online survey, question 25

Participants were also asked **whether they had been able to spend as much time as they felt they needed on learning activities** (Question 27). 50.5% of respondents reported that they had had as much time as they needed, 36.6% said that they had not had quite as much time as they needed, 10.3% said that they had had much less time than they thought they needed and 1.4% had not had any time to spend on learning activities. 1.2% reported “Don’t know”. Note that these figures do not include those that did not respond to the survey, many of whom did not complete any CFtP activities (see Table 3).

Participants were also asked **whether they had experienced any problems or issues when writing up their case studies** (Question 52). Results are shown in Figure 13 below.



Figure 13: Problems or issues when writing up case studies



Source: SPH online survey, question 52

The areas which caused the most difficulty were knowing what a good case study would look like (58% were not sure) and being sure just what was needed (54% felt unsure). These are explored in more detail in section 2.4.6 (Outcome 6: Participants understand the rationale for and requirements of the proposed approach), below.

18% of the 408 respondents to this question stated that they did not have a good example they could use. 14% of the 411 respondents to this statement said that they did not have enough time to complete it as fully as they would have liked.

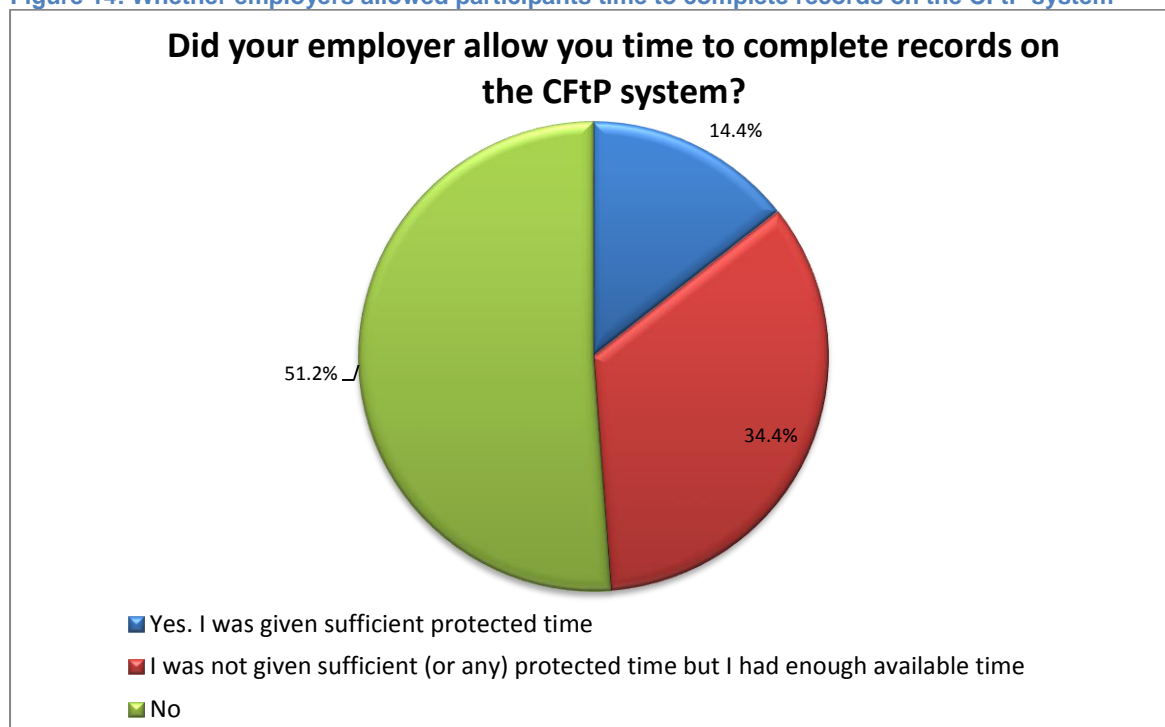
Respondents also reported identifying benefits from carrying out case studies. For example, one person stated *"It was an area I really enjoy and I feel I benefitted greatly and so will our customers from my learning"*. Another stated that *"I think this is a useful approach"*.

Ultimately, satisfactory completion of entries to the CFtP (or CPD) system, and hence continued professional registration with the GPhC is the responsibility of the individual pharmacy professional. However, the support of their employers can be important in encouraging participation. The approaches and behaviours of employers is explored here.

Participants were asked **whether their employers were aware that they were taking part in the CFtP pilot** (Question 28). 65.0% reported that they were, 26.9% reported that they were not, and 8.13% stated that they were self-employed.

They were also asked **whether their employer allowed them time to complete records on the CFtP system**. As shown in Figure 14 below, just over half (51.2%) said no.

Figure 14: Whether employers allowed participants time to complete records on the CFtP system



Source: SPH online survey, question 29

A slightly different picture emerged when participants were asked **whether, for the process of participating in CFtP, their employers allowed them time to undertake learning activities** (Question 30). In this case, 29.0% reported that they were given sufficient protected time, 35.2% said that they were not given sufficient or any protected time but had enough available time, and 35.8% said that they were not allowed time.

When asked **whether they completed their peer discussions during working hours**, 76.9% of respondents replied “Yes”, with 23.1% replying that their peer discussions had taken place outside working hours (Question 44). Two respondents used the ‘Other’ category in Question 43 (how did you carry out your peer discussion) to raise issues about this:

*“My peer discussion took place in working hours but I will have to catch up on the work that I would have been doing. My peer works part time and undertook the review in her own time. We chatted for 45 minutes and she had obviously spent time preparing in advance, as had I.”*

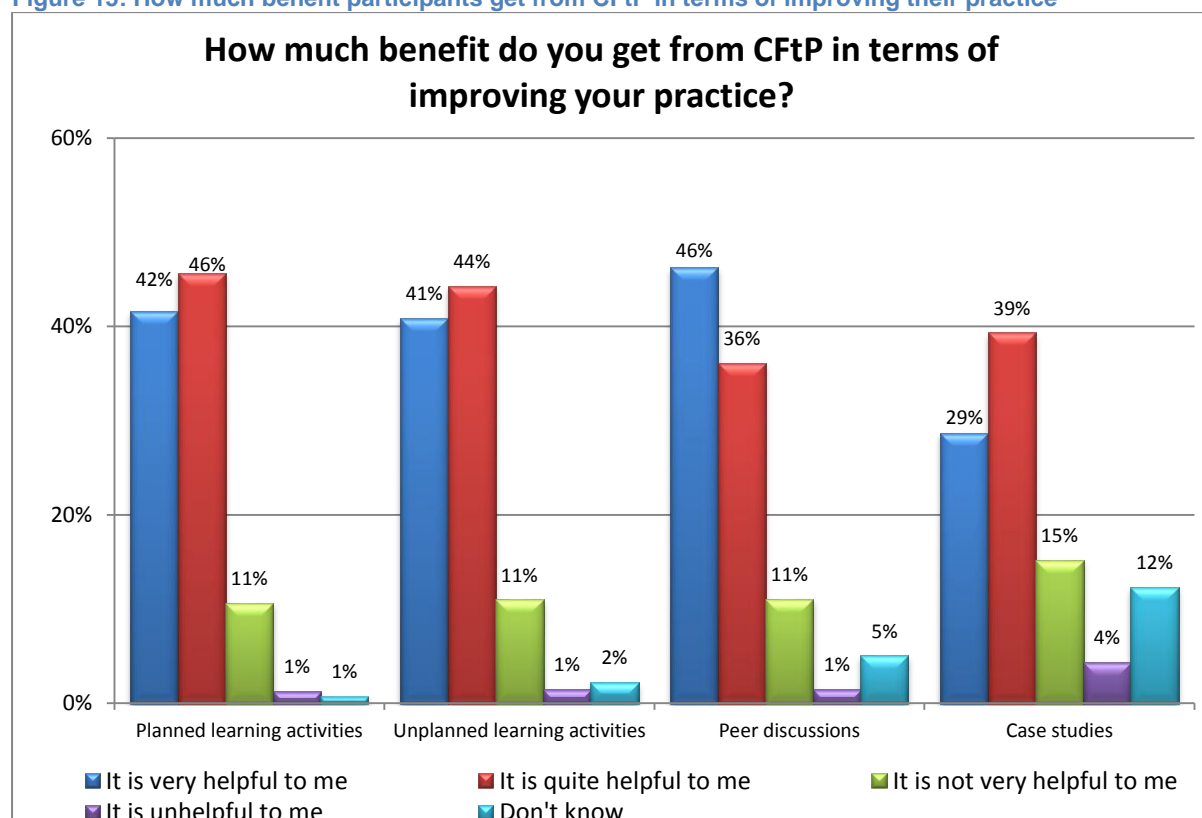
*“No protected work time to do this which is something the GPhC should look at. I feel very strongly that community pharmacists and their teams should have protected time the same as GPs and their teams.”*

The majority of respondents (69.3%) reported that their work-based appraisals were not linked to the GPhC CPD or CFtP processes (Question 31). 21.2% of respondents stated that one will partially inform the other, and 2.7% reported that the two are carried out in tandem. 2.7% stated that their organisations do not operate appraisal systems, and 4.1% answered “Don’t know”.

In contrast 67.5% felt that there would be some benefit in principle if the GPhC CPD or CFtP process was linked to their work-based appraisal system (Question 32). 15.4% felt this would not offer benefit, and 6.2% felt that it would cause problems. 10.9% answered “Don’t know”.

Pharmacy professionals are more likely to actively participate in CFtP where they feel it adds value to them. Participants were therefore asked how much benefit they got from the CFtP system in terms of improving their practice (Question 54). Figure 15 below shows that 87.3% of respondents felt that planned learning activities were very or quite helpful to them. Unplanned learning was felt to be very or quite helpful to 85.2% of respondents. 82.4% felt that the peer discussions were very or quite helpful to them. In contrast, 68.1% felt that case studies were very or quite helpful to them. Conversely, 0.7% and 2.2% respectively replied “Don’t know” to this question for planned and unplanned learning. For peer discussions this figure was 5.1% and for case studies this rose to 12.4%.

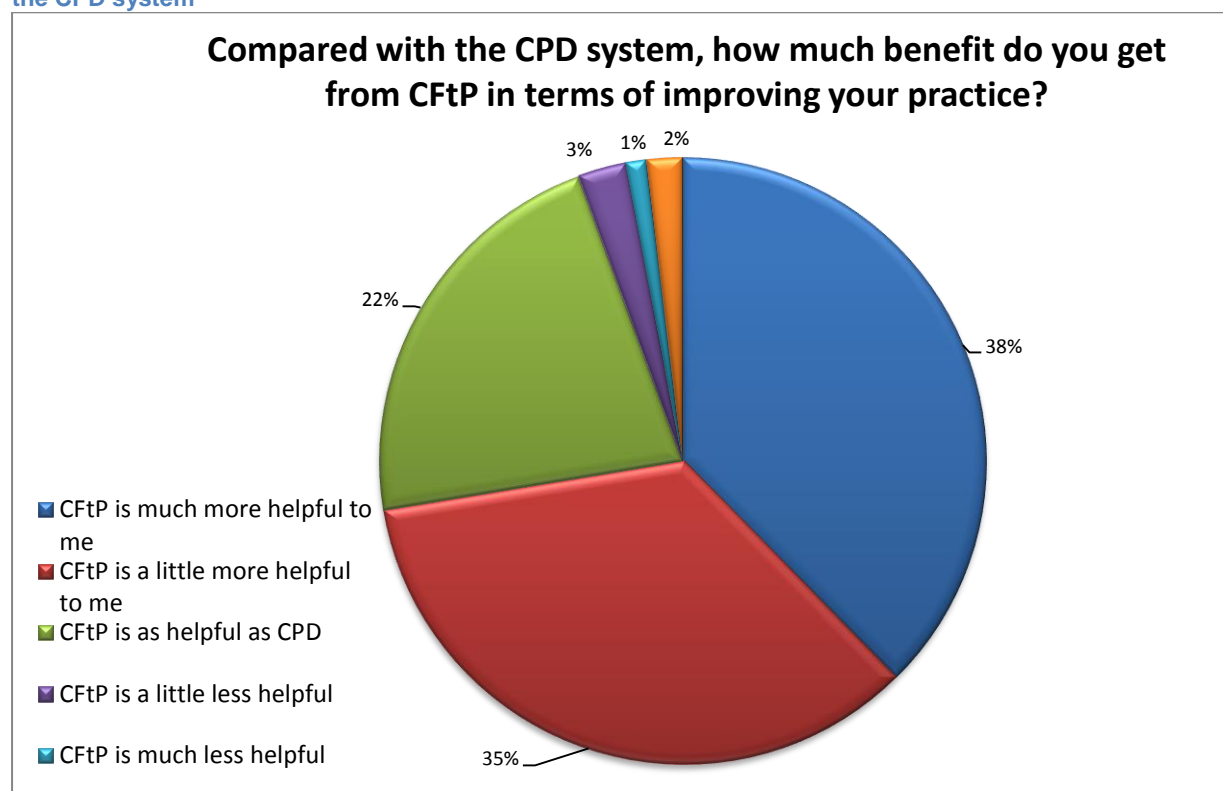
**Figure 15: How much benefit participants get from CFtP in terms of improving their practice**



Source: SPH online survey, question 54

When asked whether they get more benefit in terms of improving their practice from the CFtP system compared with the CPD system (Question 55), 37.6% reported that they found it much more helpful to them, as shown in Figure 16 below. 34.8% found it a little more helpful. 1.1% found in much less helpful.

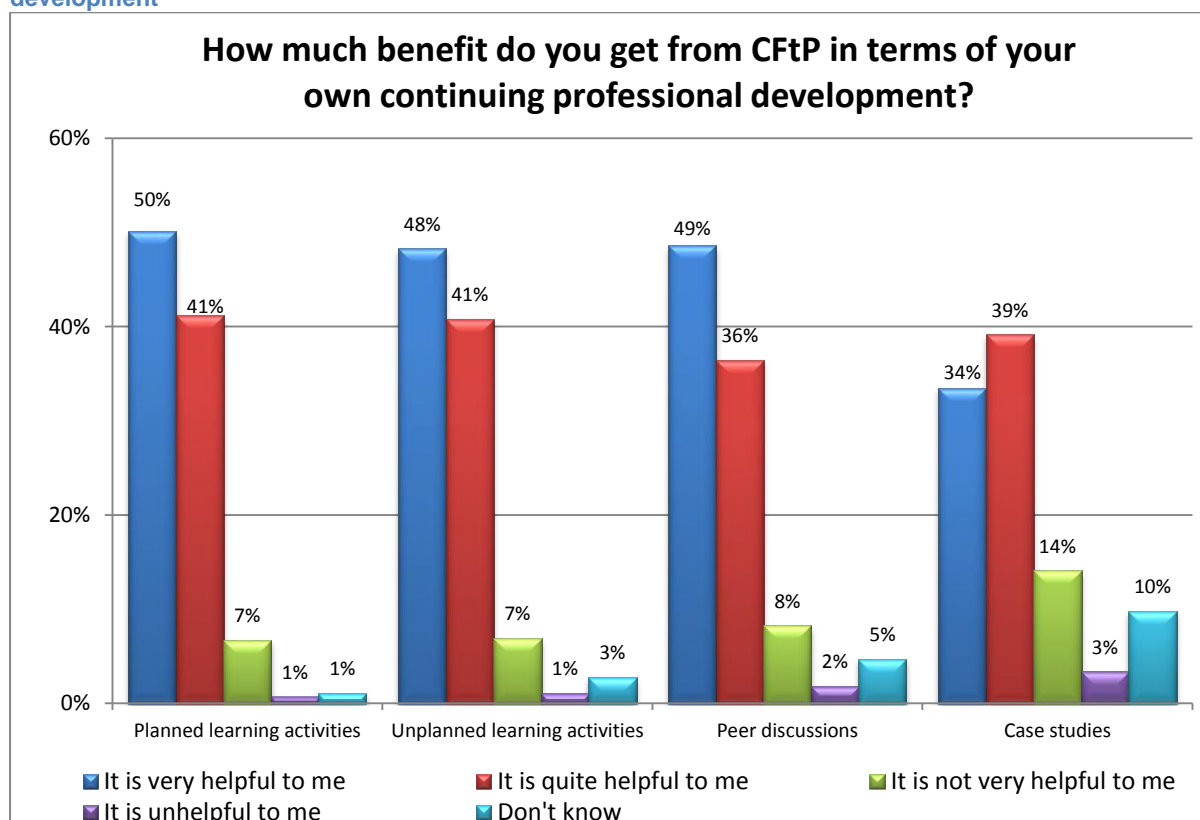
**Figure 16: How much benefit participants get from CFtP in terms of improving their practice compared with the CPD system**



Source: SPH online survey, question 55

The survey also asked **how much benefit each component of CFtP gives to their overall continuing professional development** (Question 58), and the results are shown in Figure 17 below. This shows that for planned learning, unplanned learning and peer discussions respectively, 91.4%, 89.1% and 85.2% of respondents felt that CFtP was very or quite helpful to their own continuing professional development, whereas 72.7% felt that case studies were very or quite helpful. Those who replied “Don’t know” for planned learning, unplanned learning and peer discussions were 1.1%, 2.8% and 4.7% respectively, and the figure for case studies was 9.8%.

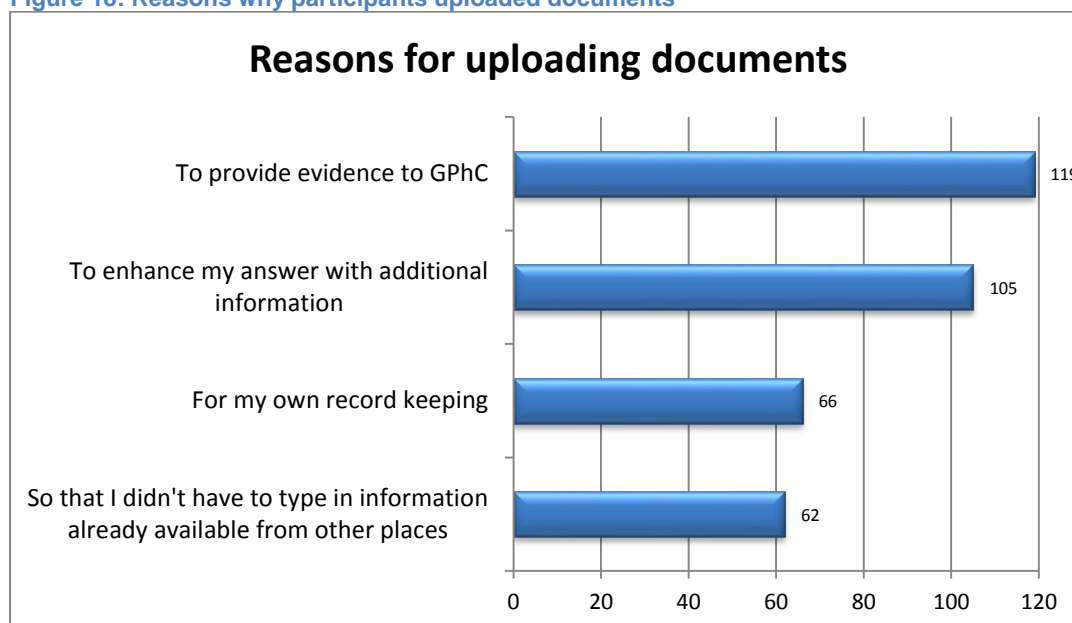
**Figure 17: How much benefit participants get from CFtP in terms of their own continuing professional development**



Source: SPH online survey, question 58

To add benefit to pharmacy professionals, the ability to upload documents was added to the CFtP system, which was not available in the CPD system. 20.3% of respondents stated that they had uploaded documents to the system (Question 20). Their reasons for doing so are shown in Figure 18 below (Question 21). 119 people reported uploading documents to provide evidence to the GPhC. 66 uploaded documents for their own record keeping, and 62 so that they didn't have to type in information available from other places. It is suggested that if this functionality is retained in the final version of the framework, the GPhC is clear in its guidance as to how they intend to use any uploaded documents, and benefits users may find to themselves of uploading documents.

Figure 18: Reasons why participants uploaded documents

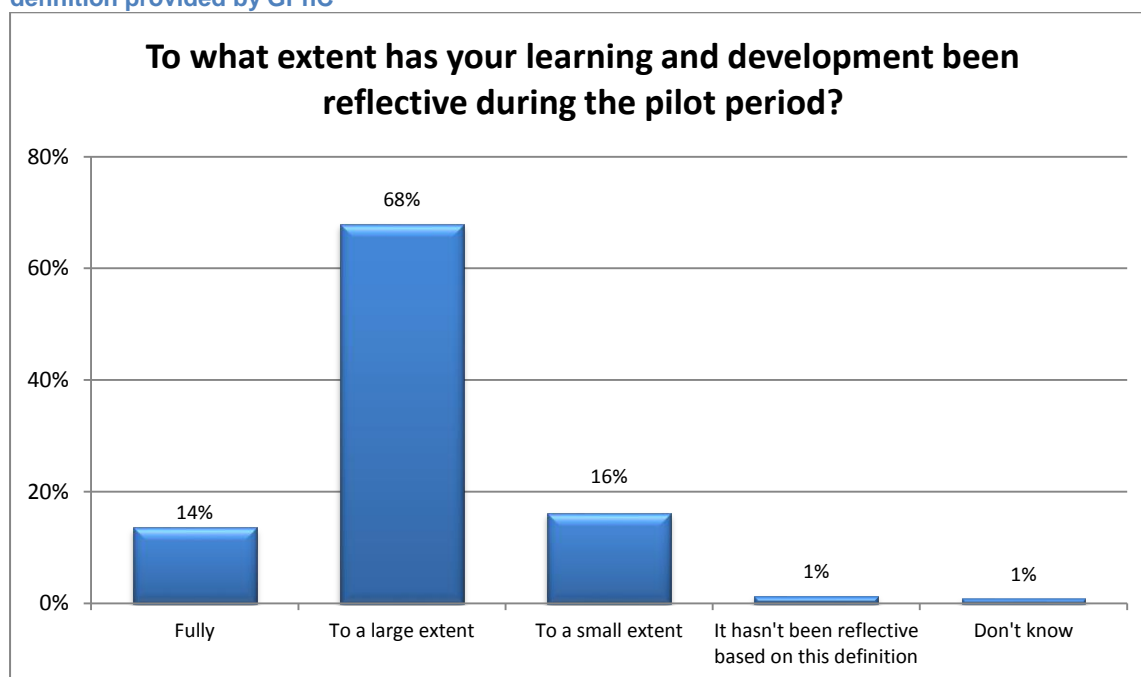


Source: SPH online survey, question 21

### 7.3.3 Outcome 3: The proposed approach encourages reflective learning, demonstrates an impact on patients or service users and where appropriate, is reflective of the GPhC Standard 3 - Communicate Effectively

When asked **to what extent their learning had been reflective**, based on the definition provided by GPhC, noted previously, 2.3% said either that it had not been reflective based on this definition or “Don’t know”. The remaining respondents (97.7%) said it had been reflective, with 81.5% saying it was reflective fully or to a large extent, as shown in Figure 19 below.

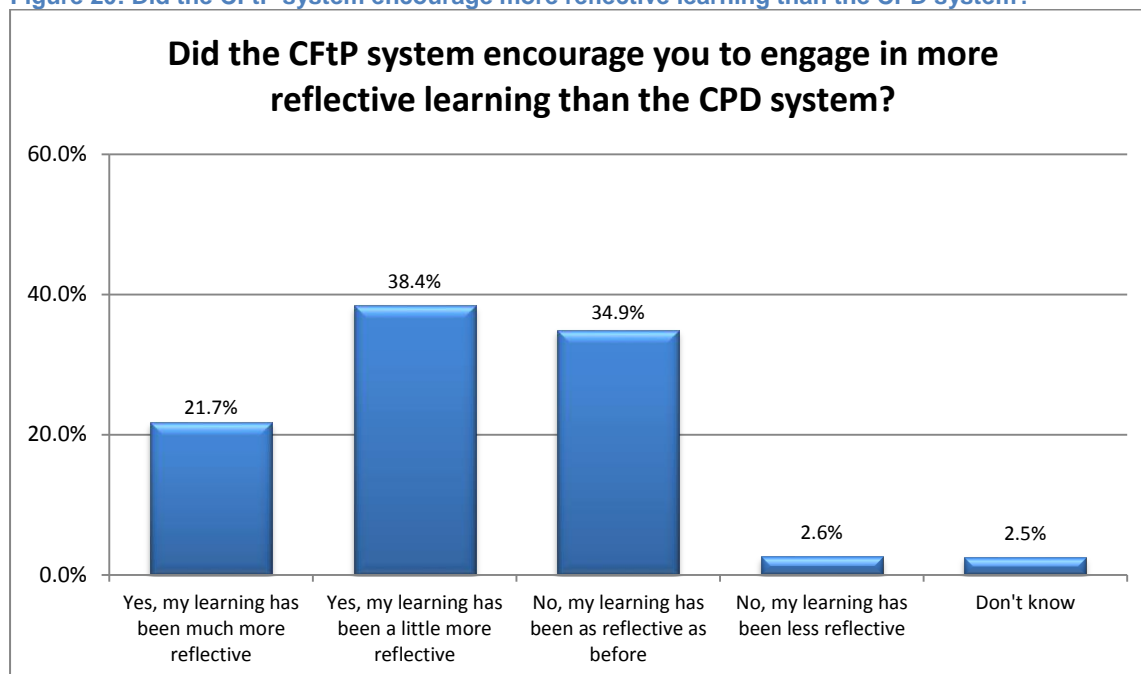
**Figure 19: The extent to which participant's learning and development has been reflective, according to the definition provided by GPhC**



Source: SPH online survey, question 23

Further, the majority of respondents (60.0%) felt that the CFtP system encouraged them to engage in more reflective learning than the CPD system, with 34.9% reporting that their learning was as reflective, as shown in Figure 20 below.

**Figure 20: Did the CFtP system encourage more reflective learning than the CPD system?**

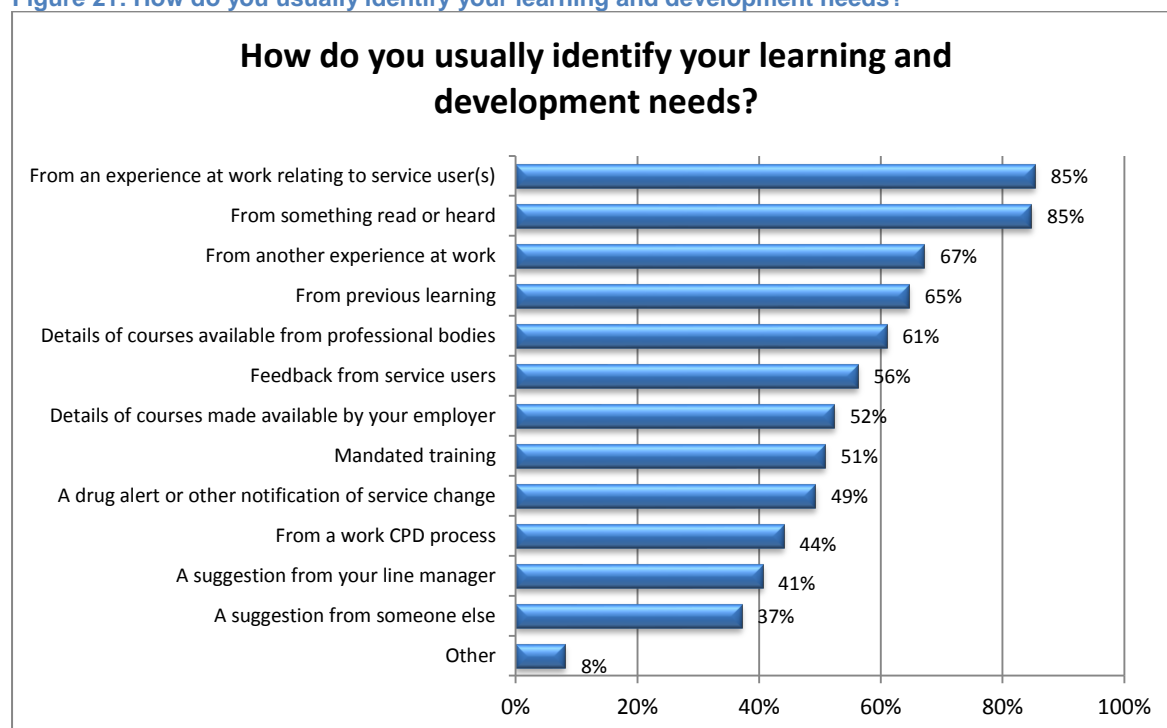


Source: SPH online survey, question 24

One aim of the CFtP framework is to encourage reflection on future learning needs. When asked **“Have you identified any future training needs as a result of completing the CFtP pilot?”** (Question 14) 50.0% of respondents replied that they had. 34.7% had not and 15.0% did not know.

Respondents were asked **how they identified their learning and development needs** (Question 13), and the results are shown in Figure 21 below. 85% of respondents stated that they identified their learning needs from an experience at work relating to service users(s) and 85% also noted that they identified their learning needs from something read or heard.

**Figure 21: How do you usually identify your learning and development needs?**

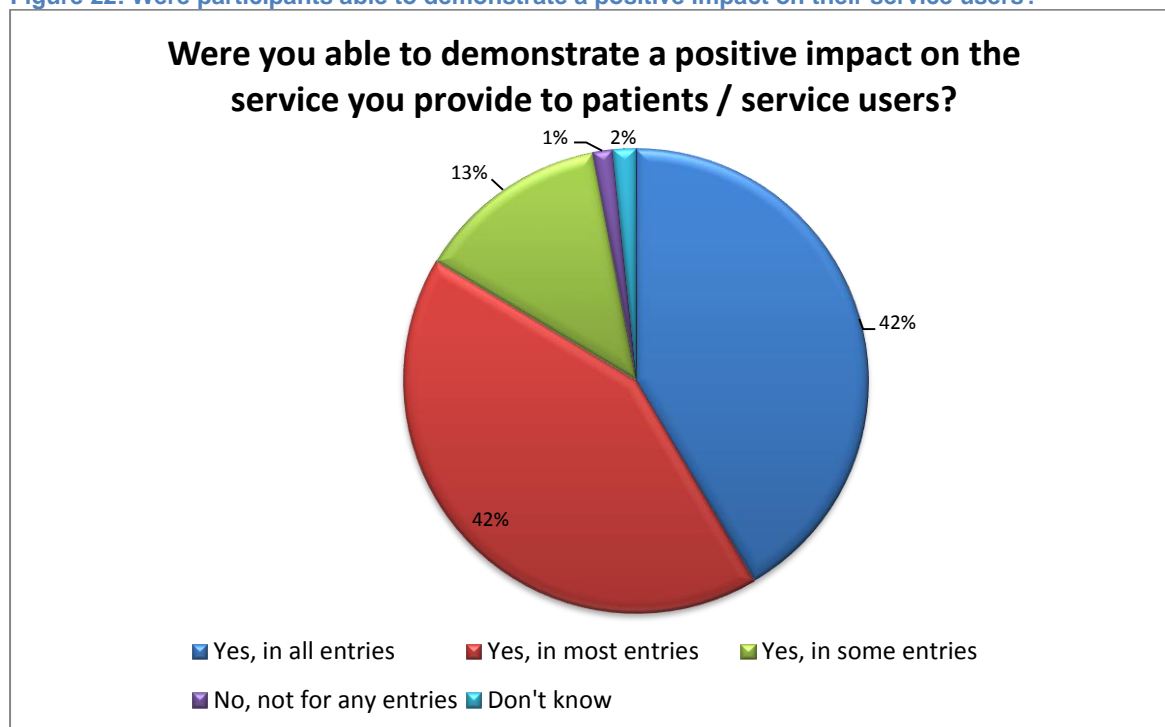


Source: SPH online survey, question 13

The GPhC wish to encourage pharmacy professionals to demonstrate the positive impacts that their actions have had on patients or service users, and so survey participants were asked **“For each of the entries you made to the pilot system, were you able to demonstrate a positive impact on the service you provide to patients/service users”** (Question 26). Responses are shown in Figure 22 below. This shows that 41.6% of respondents reported that they were able to demonstrate a positive impact on patients / service users in all entries made, with 42.1% being able to demonstrate this in most entries and 13.4% in some entries.



Figure 22: Were participants able to demonstrate a positive impact on their service users?

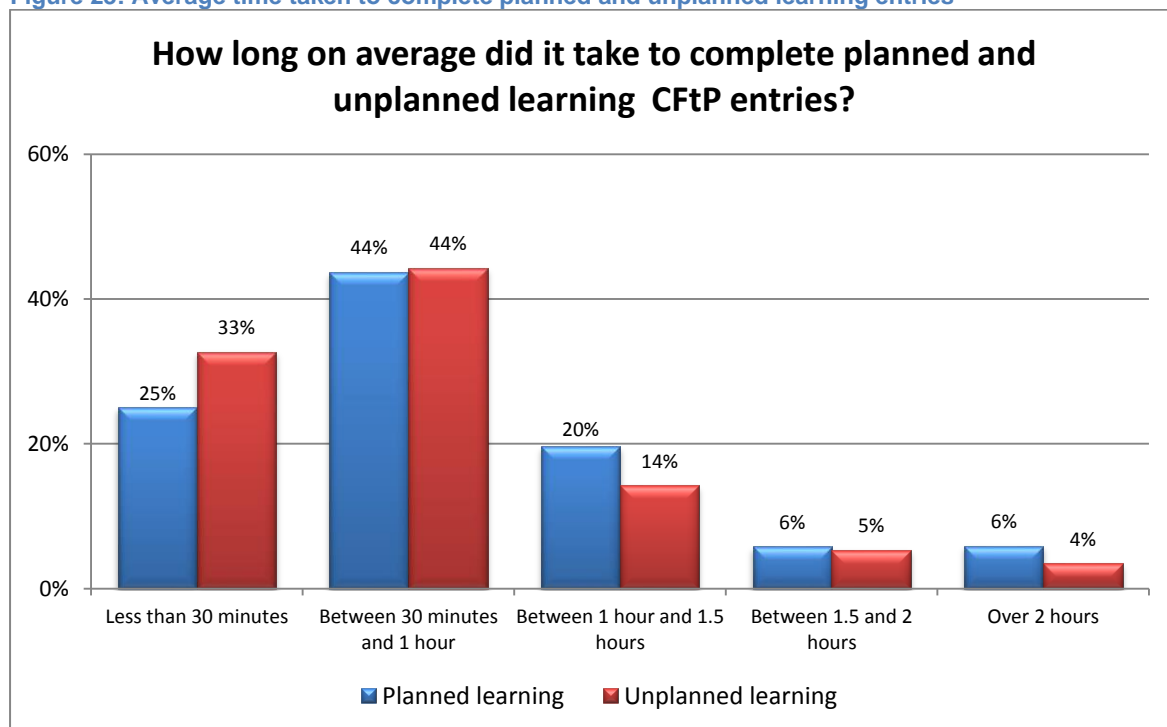


Source: SPH online survey, question 26

#### 7.3.4 Outcome 4: The proposed approach incurs negligible additional time and other costs

To understand the implications of the proposed framework in terms of pharmacy professional's time, participants were asked **how long it took them to complete each of their planned and unplanned learning entries in the CFtP system, including time to reflect on what to include** (Questions 34 and 37). As shown in Figure 23 below, in most cases these took under 1 hour.

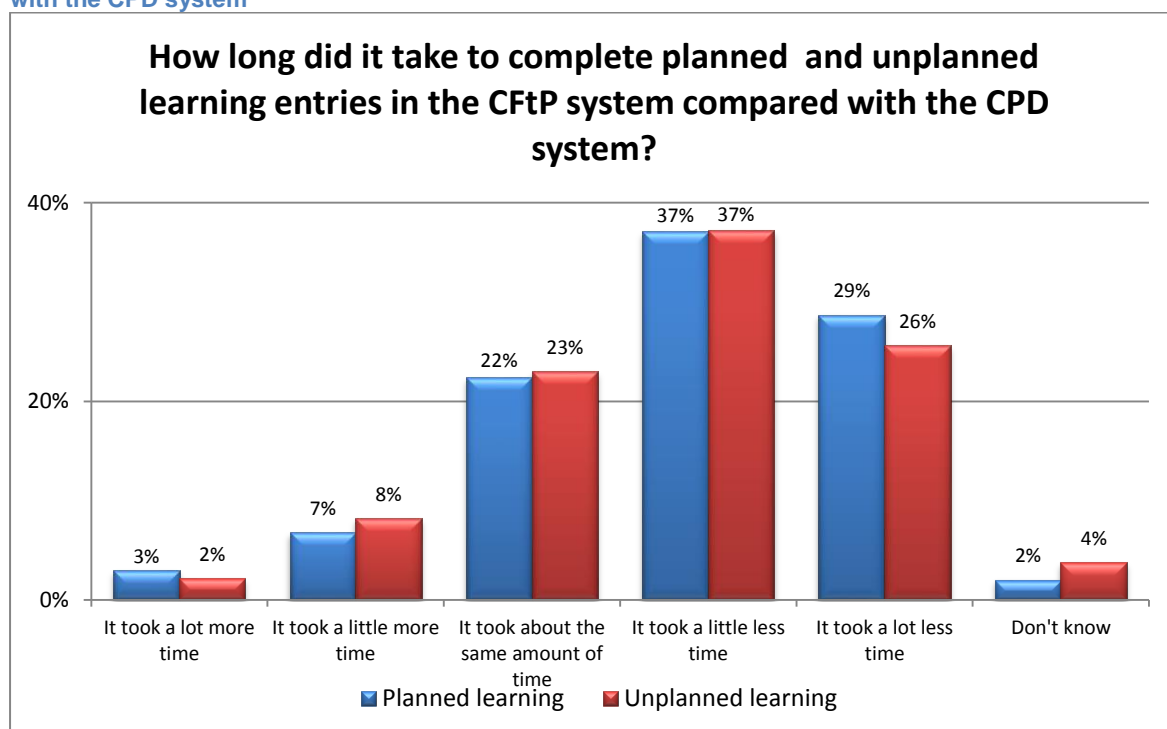
**Figure 23: Average time taken to complete planned and unplanned learning entries**



Source: SPH online survey, questions 34 & 37

The majority of respondents reported that it took less time to complete planned and unplanned learning entries in the CFtP system than in the CPD system (Questions 35 and 38), as shown in Figure 24 below, with 29% and 26% respectively noting that it took a lot less time.

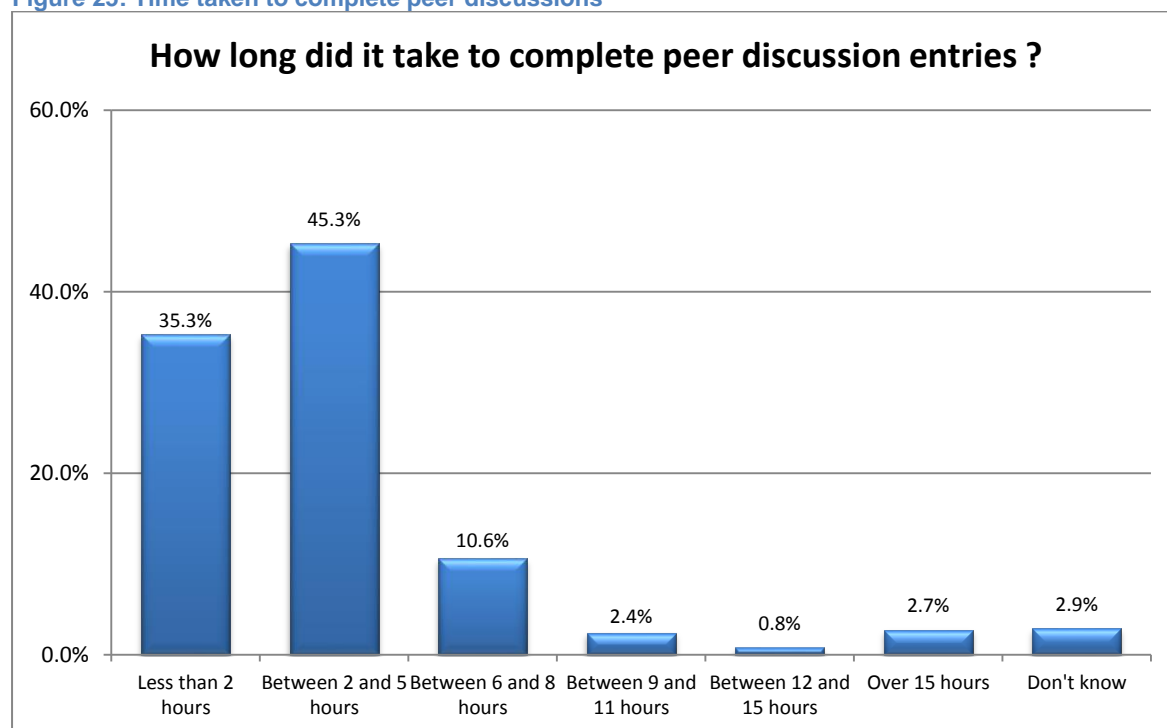
**Figure 24: Time taken to complete planned and unplanned learning entries in the CFtP system compared with the CPD system**



Source: SPH online survey, questions 35 and 38

The majority of respondents reported that peer discussion took under 5 hours to complete, including time taken to identify a peer, to make arrangements for the discussion, prepare for and hold the discussion, write up the entry in the CFtP system etc.(Question 46), as shown in Figure 25 below. 16.5% of respondents reported that the time taken was 6 hours and over.

**Figure 25: Time taken to complete peer discussions**

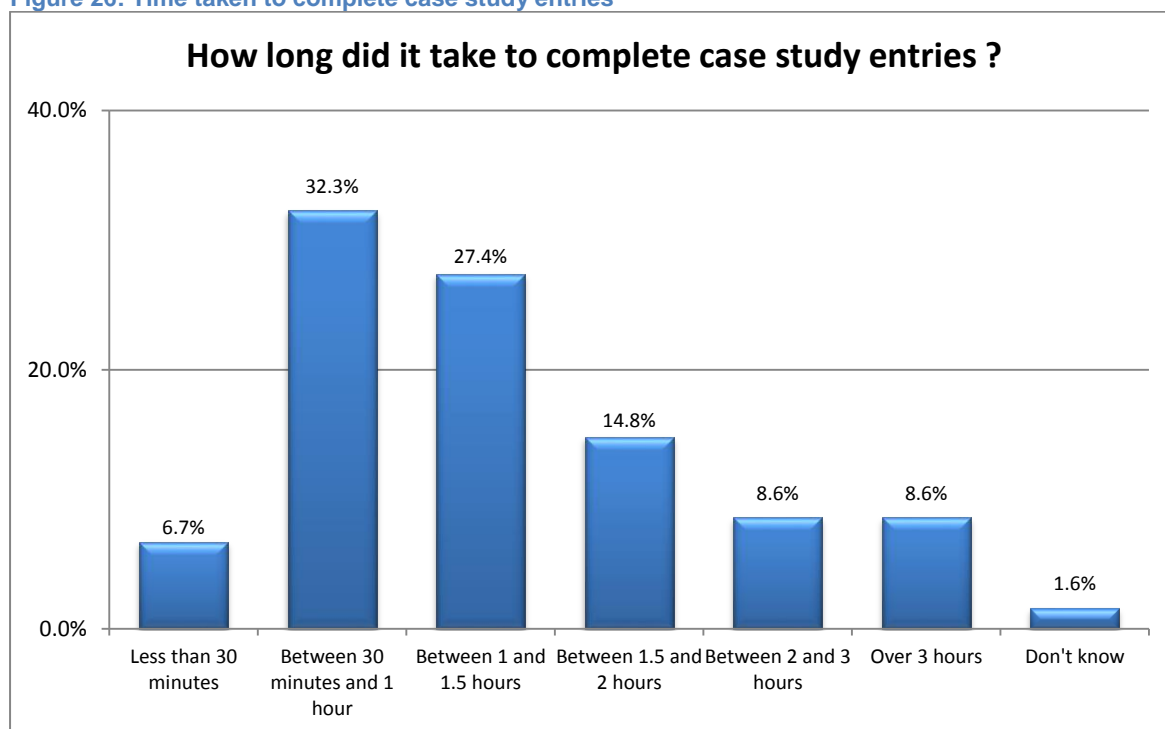


Source: SPH online survey, question 46

Within this, 21.4 percent reported that the discussion itself took less than 30 minutes (Question 47). For 44.6% of respondents the discussion took between 30 minutes and an hour. 20.4% stated that it took between 1 and 1 ½ hours, and 5% stated they took over 2 hours.

Respondents were asked **how long it took to complete their case study entries, including the time taken to reflect on what to include** (Question 53). The results are shown in Figure 26 below. This shows that most commonly, for 32.3% of respondents, this took between 30 minutes and 1 hour. For 17.2% of respondents, it took over 2 hours.

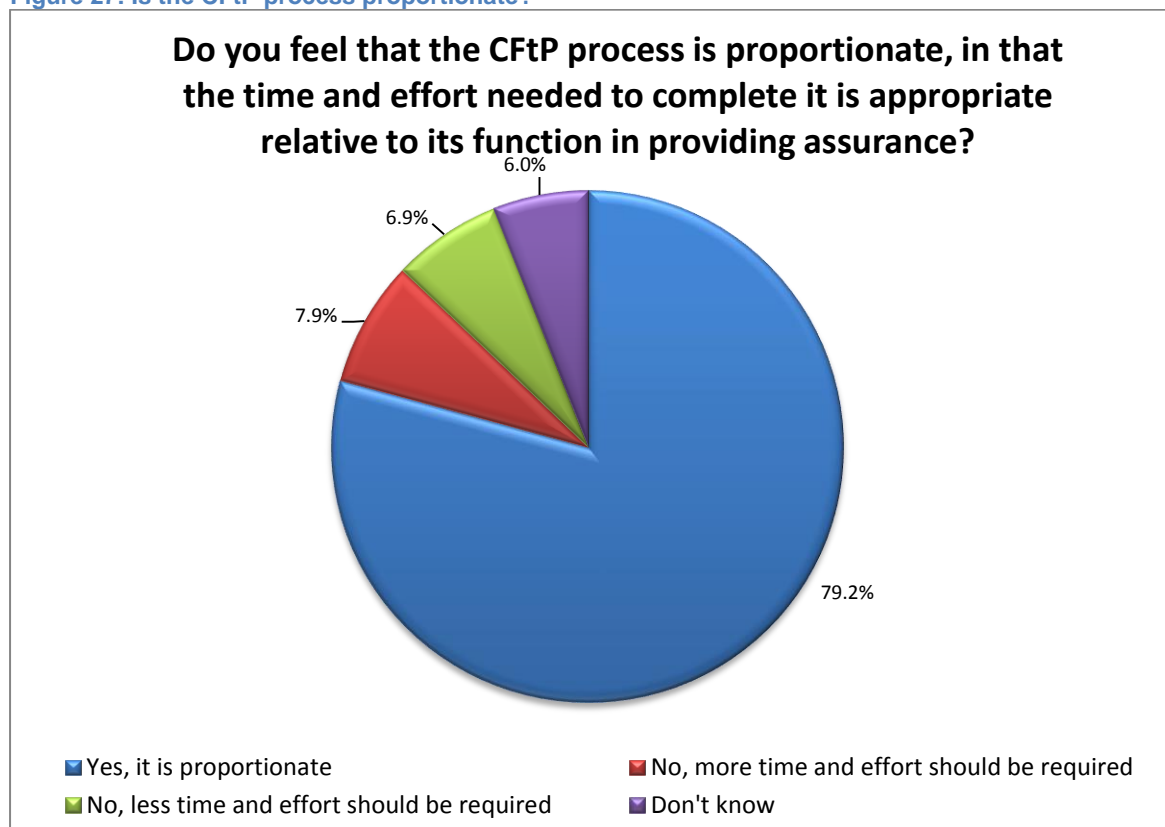
Figure 26: Time taken to complete case study entries



Source: SPH online survey, question 53

In addition, respondents were asked **whether they felt that the CFtP process is proportionate, in that the time and effort needed to complete it is appropriate relative to its function in providing assurance of pharmacy professionals' continuing fitness to practice** (Question 62). Figure 27 below demonstrates that 79.2% of respondents considered the process to be proportionate. 7.9% felt that more time and effort should be required. However, a similar percentage (6.93%) felt that less time and effort should be required. 6.0% recorded "Don't know".

Figure 27: Is the CFtP process proportionate?



Source: SPH online survey, question 62

Comments made to expand upon this included the view that the peer conversation and case study add to the time taken overall, compared with the CPD system, for example

*"The peer and case reviews cause it to be more time consuming than the old system, I don't feel like I've gained more from them. The peer discussion is valuable if occurring in a natural way, but to try and force it causes it to become needlessly more tedious and complicated to manage."*

*"In a way the process is more streamlined and yet some parts of it are too time consuming such as the peer review and case study so in my opinion the latter negates the former making it more cumbersome."*

Their potentially different impact on different groups of pharmacy professionals was discussed by one respondent, who said,

*"I can see peer discussions and case studies needing a lot of support to introduce to Pharmacy Technicians. Should consider introducing terminology at trainee level in preparation for registration."*

Another comment related to the role of CFtP depending on career stage:

*"Different situations require different levels of CPD. For example because I changed from hospital pharmacist to community locum I have had a very steep learning curve this year. To meet this I have undertaken lots of self-directed reading, distance learning packs, courses, etc. I could have written up 40 plus entries this year - but I would hope next year this has eased off. I don't think I would have been Fit to Practise"*



*if I had not put this huge effort into responding to minor ailments, all contractual services, etc.”*

Positive comments included:

*“It's got a greater variety of activities and generally takes less time than the old system used to - and hopefully it is more advantageous.”*

*“I felt the time taken to complete the CFtP system was similar to the CPD system but the CFtP system encouraged more reflection which had a greater impact on improving practice.”*

*“Entry was much faster than the previous recording method, which, as I always arrive at work early and leave late, was a big plus - I do not want to have to spend precious time at home working on my CPD! However, I think that back up evidence is required.”*

A number of respondents noted the need to carry out CFtP activities outside their working hours, for example:

*“Time should be given during working hours. we all lead busy lives and this is why notes are made to be transcribed at a later date”.*

*“It would be nice to have protected study time (even if just a small amount) from employer to plan and record CPD, as I am certain that it is more beneficial to record entries as soon as possible after completion rather than completing some time afterwards.”*

*“I would be happy to spend more time providing evidence for assurance, but planned study leave would be helpful as is the case in other professions to ensure there is protected time for CPD and its recording”.*

Links with the RPS Faculty system were discussed:

*“I think the GPhC system is adequate for continuing fitness to practice - the baseline. For those who want to do more than the minimum, the RPS Faculty system is more suited to supporting my personal development, but I must not have to complete both systems.”*

*“I think that if it was linked to work based appraisal then it would be more robust. It could then become part of an integrated approach which recorded new learning whilst building a portfolio. The faculty system builds a portfolio but it can be difficult to identify historic/current learning within the entries when they are classed as 'ongoing' so CPD from the past 12 months can be difficult to establish.”*

### **7.3.5 Outcome 5: The proposed approach is fair and equitable**

Pharmacy professionals work across a wide range of settings, roles, working patterns etc. and individuals will be different in terms of age, gender, ethnicity and other characteristics. It is essential that CFtP is equally accessible and useful to all. A number of questions asked in the online survey were analysed by such characteristics, to test for this. As the survey was anonymous, participants were asked, but not obliged, to state the following to allow this analysis (Questions 1 to 11):



- Their role - pharmacist or pharmacy technician
- Setting(s) - academic / educational, advisory / regulatory, hospice care, hospital, primary care / GP practice, independent community pharmacy, multiple community pharmacy, industry / science, military, secure (prison / mental health)
- Country – England, Scotland, Wales
- Gender
- Working pattern – full time, part time
- Whether they are a locum
- Number of years registered – less than 5, 5 to 10, more than 10
- Ethnic group
- Whether English is their second language
- Whether they have a disability

Two particular aspects were asked about directly. Firstly, respondents were asked **if they worked full or part time** (Question 5). 173, or 28.9% of those who answered this question said that they worked part time. These were asked **whether working part time had impacted on their ability to complete the CFtP activities** (Question 6). 39 individuals responded that it had. This represents 6.5% of the 602 people who completed the survey, and 22.5% of those who stated that they worked part time. Secondly, respondents were asked whether, if English was their second language, this had impacted on their ability to complete pilot activities. 10 individuals answered “Yes” to this, which is 1.6% of the 602 people completing the survey.

Analyses by most of the characteristics listed above were carried out for a range of survey questions, selected to represent the key themes addressed throughout this evaluation.

These analyses were carried out by comparing the percentages of responses in each possible answer across each grouping within a category, as shown in Table 18 below. This was done manually by visual checking, as the range of response types varied, making tests of statistical significance less practicable. The small numbers shown in a number of groupings also made these less reliable and useful.

Where the individual had not recorded which category they belonged to, except as in the case of ethnicity, where they selected not to state their ethnicity, these results were not analysed. Similarly, respondents not answering the question were excluded from that analysis.

**Table 18: Example of analyses of question responses by characteristic**

<b>To what extent has your learning and development during this pilot period been reflective?</b>				
Question 23				
<b>Number of responses</b>				
<b>Role</b>	<b>Pharmacist</b>	<b>Pharmacy Technician</b>	<b>Not stated</b>	<b>Total</b>
Fully	71	6		<b>77</b>
To a large extent	326	58	2	<b>386</b>
To a small extent	72	19	1	<b>92</b>
It hasn't been reflective based on this definition	6	2		<b>8</b>
Don't know	3	2		<b>5</b>
No response given	23	11		<b>34</b>
<i>Total</i>	<i>501</i>	<i>98</i>	<i>3</i>	<i><b>602</b></i>
<b>Total of all responses given</b>	<b>478</b>	<b>87</b>	<b>3</b>	<b>568</b>
<b>Percentage of responses</b>				
<b>Role</b>	<b>Pharmacist</b>	<b>Pharmacy Technician</b>	<b>Not stated</b>	<b>total</b>
Fully	15%	7%	0%	<b>14%</b>
To a large extent	68%	67%	67%	<b>68%</b>
To a small extent	15%	22%	33%	<b>16%</b>
It hasn't been reflective based on this definition	1%	2%	0%	<b>1%</b>
Don't know	1%	2%	0%	<b>1%</b>
No response given	5%	13%	0%	<b>6%</b>
<i>Total</i>	<i>105%</i>	<i>113%</i>	<i>100%</i>	<i><b>106%</b></i>
<b>Total of all responses given</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: SPH Online survey

It should be noted that all individual pharmacy professionals will have been categorised into the characteristic groupings given, and that these have been analysed separately, so for example, a particular pharmacy technician may also have their results shown as a person working in community pharmacy, as a person working full time, of Indian ethnic grouping etc.

A summary of the analysis carried out is shown in Appendix 6 (Analysis of Online Survey Results by Characteristic). Review of all these questions showed that overall, no individual grouping was consistently advantaged or disadvantaged. Some variations in responses to particular questions were noted, and these are explored in the Appendix. Variations most commonly occurred between settings, which may be as a result of the large number of settings and hence smaller numbers of individual in each. These results should be treated as indicative, particularly where there are small numbers in any one grouping, and an issue to consider for further investigation as the GPhC moves forward.

Examples of findings of interest include:

When asked “**Did you have enough time without distractions to think through what your learning and development needs were**” (Question 25), responses ranged from 17% of respondents working in multiple community settings saying that they disagreed or strongly disagreed, to 36% in hospital settings.

In response to the question “**How soon after completing a learning activity did you make an entry about it in the system?**” (Question 15), 26% of those in independent community pharmacies replied that they completed their entries within a week, compared with 9% in hospitals.





There was a wide range of responses to the question “**Approximately how long did it take you to complete a peer discussion?**” (Question 46). For example, 62% of those who have been registered for under 5 years reported that their peer discussions (including the time to arrange etc.) took 5 hours or less, compared with 82% both for those who have been registered between 5 and 10 years, and those who have been registered for more than 10 years.

Relevant comments received include:

*“It is galling to see those who sit at computers all day completing their CPD whilst those of us out on wards have no time in the working day.” (Question 62)*

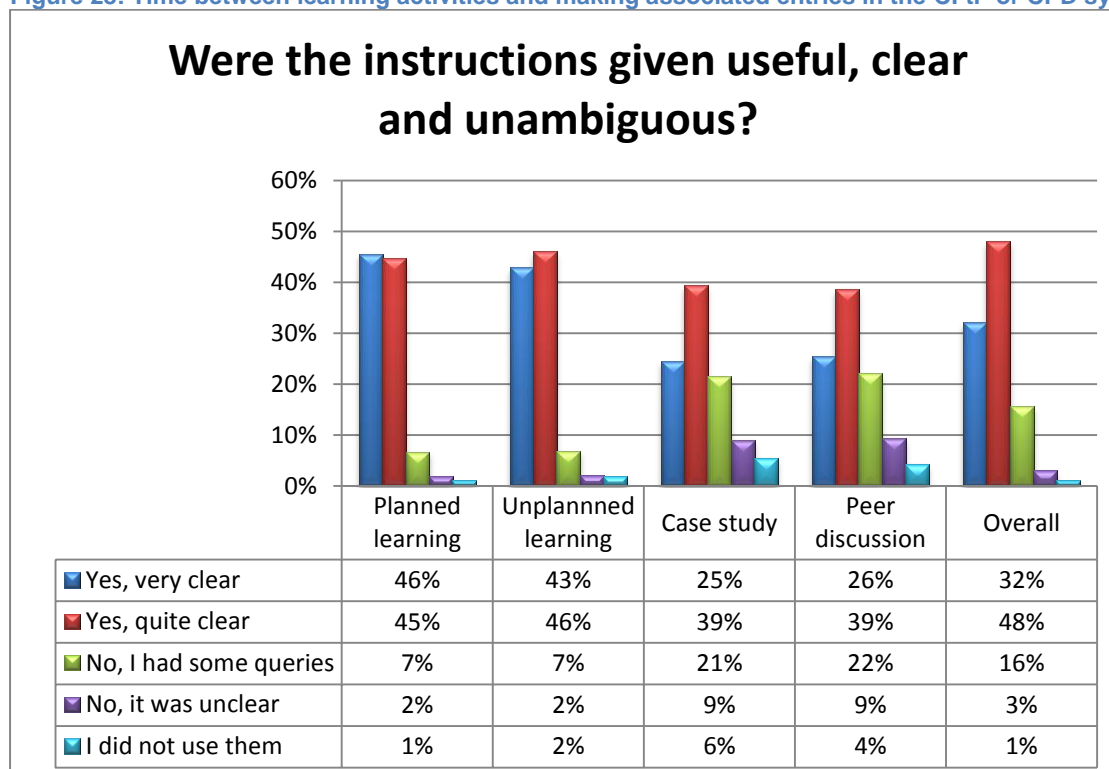
*“I work part-time, so in many ways I now have more time to reflect on and record my learning. The same may not be said when I was working in excess of 60 - 70 hours per week, where I would always be learning, but the quality of my recording may not have reflected that”. (Question 62)*

*“Peer discussion and case study have proved time consuming - as a locum finding a peer was very difficult - case study was also a problem as I may not be working in the same pharmacy for a long enough period of time or regularly enough to be able to obtain feedback about whether the change made to my practise was beneficial”. (Question 62)*

### **7.3.6 Outcome 6: Participants understand the rationale for and requirements of the proposed approach**

Participants were asked about the documentation about the pilot and how to use the pilot system provided by GPhC. Figure 28 below shows that participants found the guidance relating to planned and unplanned learning much more useful, clear and unambiguous than that for the case study and peer discussion. Higher numbers also reported that they did not use the guidance for the case studies and peer discussion, which may relate to the fact that completion rates for these were lower.

Figure 28: Time between learning activities and making associated entries in the CFtP or CPD systems



Source: SPH online survey, question 22

Respondents were invited to make additional comments, and 141 were received.

A number of these related to technical issues with the software used. However, different software will be used in any final version.

Other themes identified included:

- Difficulty in seeing how to apply to different settings, such as commissioning, or roles such as a locum, both overall and particularly for case studies and peer discussions. This included a comment that “As a relief pharmacist working part time and in different pharmacies I found difficulty in doing case studies as they need one to work in the same pharmacy most of the time”
- Desire to have relevant documentation / guidance (for example Standard 3) within the system. For example “it would be helpful if the templates incorporated the key learning point required to be included rather than a blank sheet”
- Some confusion as to the number of entries needed, with reference made to understanding changing as different communications from the GPhC were received. It would appear that some participants interpreted the initial guidance to mean that four entries rather than four types of entry were required, and found that subsequent email communications from the GPhC clarified this for them
- Concern about having to record the details of the person acting as a peer
- Difficulty in identifying relevant case study topics, and finding the examples in the guidance unhelpful



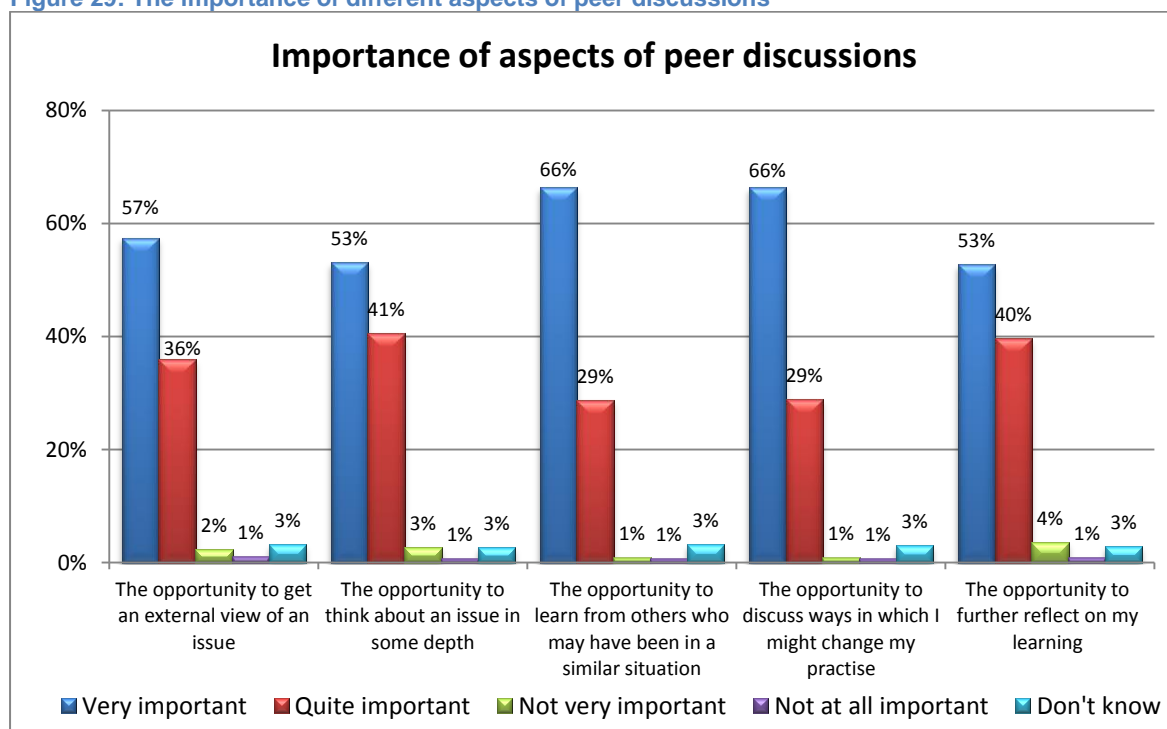
- Differing interpretations of the term 'case study', for example "The case study is not really what I would consider to be a case study"
- Not being clear on the differences between the different types of entry, for example "I found it quite hard to understand what made a learning activity suitable for a case study type of entry rather than a planned learning entry", and "The difference between the case study and the planned/unplanned learning was a bit unclear as they sometimes overlap. Something that is planned/unplanned could be made into a case study and vice versa. Think more information about what is intended by the 'case study' category would be useful. How does it differ from unplanned/planned?"
- A perception that the overall process and case studies in particular required demonstrating an impact on patients as opposed to patients or service users
- Difficulty in demonstrating the impact of learning when in non-operational roles, where any impact may take some time to take effect, or be more diffuse and less discernible
- The suggestion that some kind of proof of learning should be demanded
- The suggestion to make the system available via an app
- Not being clear about how much information to provide
- Consistent use of the term 'peer review' rather than 'peer discussion' suggesting potential confusion as to the purpose of the peer discussion
- A desire for more guidance from the GPhC about their expectations about peer discussions and the role of the peer
- One person noted that "The example entries provided actually made me feel that my learning was totally inadequate"
- The use of different tenses could be confusing, for example "I feel the different terminologies and tenses in each scenario can sometimes be confusing and not offer specific guidance. It also makes it harder to enter the whole scenario straight away, and does not allow for reflection"
- A suggestion was made that the GPhC show CPD steps via a flowchart

There were a number of positive comments, with the following themes emerging:

- The guidance was clear and helpful, for example "I found the worked examples very useful"
- Peer discussions were more useful than expected
- Those who had attended face to face meetings held by the GPhC to explain the process found these very helpful

**Peer discussions serve multiple purposes.** Respondents were asked how important they considered a number of aspects (Question 39), and Figure 29 below shows that the majority considered all of these to be either very or quite important, suggesting that they understood these purposes of the discussions.

Figure 29: The importance of different aspects of peer discussions



Source: SPH online survey, question 39

Participants were invited to comment on other aspects. Particular examples include:

*"To share experiences particularly in more unusual job roles"*

*"The opportunity to pressure test what I think about myself and my development and get honest feedback from others which will further support and develop me"*

*"It is great to get a second opinion and have another professional to chat with about complicated issues"*

*"The opportunity to have my ideas challenged; an open dialogue to help me generate additional ideas for change / improvement; the opportunity for a neutral, critical review of an issue by others; learning from the experience of others"*

*"So long as you have a commitment to change and adapt it is a very useful way to complete your knowledge and identify gaps"*

*"To be absolutely honest this was the part of the pilot that I felt would be of the least use to me or my patients. It turns out that this was the most useful part of the whole exercise"*

*"This is a brilliant thing to include in CFtP and should be encouraged as a way of working – we have so much to share and learn from each other as a profession and the more we do this the better!"*

*"My peer did not have such and in depth knowledge and experience as myself"*

*"As a community pharmacist you are very isolated and the opportunity to talk to peers is invaluable"*

*“This would prevent pharmacists who may think of submitting entries done by somebody else – prevents fraudulent practice”*

Pilot participants were informed that their peer could be from within or outside the pharmacy profession, and someone in a different role to their own. Figure 30 below shows the range of peers selected (Question 41). This shows that respondents selected from a range of professions, organisations and job roles, suggesting that they understood this element of the guidance. 20 respondents recorded details of their peer under the ‘Other’ category, and analyses of these responses are in line with this assessment. However, a number of comments received to Question 40, **“How easy was it for you to identify a peer who was willing to take part in a peer discussion with you”** highlighted a small number of respondents who were unable to hold a peer discussion as they could not identify another pharmacy professional in their sphere of practice, suggesting that they had not understood this part of the guidance.

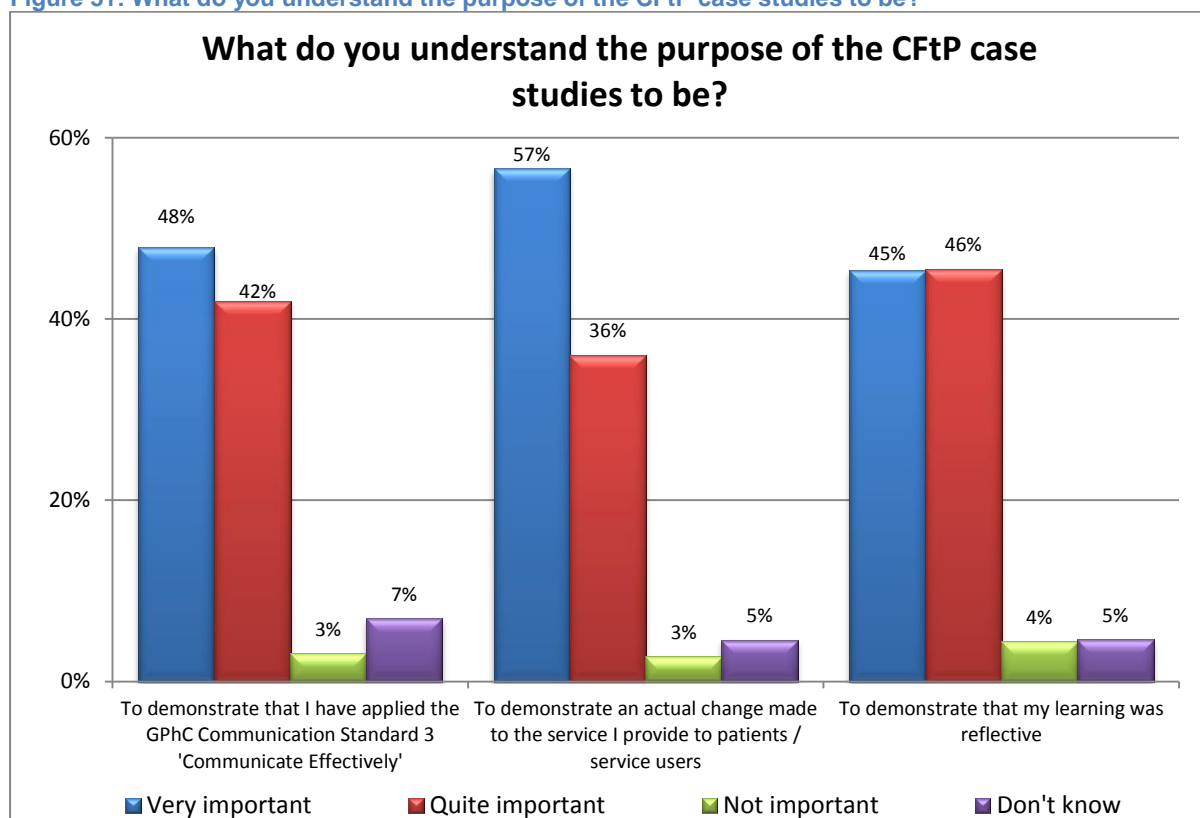
**Figure 30: Who was your peer?**



Source: SPH online survey, question 41

Participants were also asked **“What do you understand the purpose of the CFtP case studies to be?”** (Question 48). Responses are shown in Figure 31 below. This shows that 89.9% of respondents felt that it was very or quite important to demonstrate that they had applied the GPhC Communication Standard 3. 92.6% stated that they felt that it was very or quite important to demonstrate an actual change made to the service they provide to patients/service users and 90.0% reported that they felt it was very or quite important to demonstrate that their learning was reflective. For each of these areas respectively, 7.0%, 4.6% and 4.6% gave a response of “Don’t know”

Figure 31: What do you understand the purpose of the CFtP case studies to be?



Source: SPH online survey, question 48

A number of comments were also given in answer to this question. The following exemplify these:

*"I found this one particularly difficult and had to write to ask for guidance. I work in academia and found it difficult initially to identify a topic that I felt related to Standard 3 – I think I was too literal in my interpretation of it"*

*"More guidance for case studies required, the examples given were not as directive so I was unsure if my case study was appropriate"*

*"This is not what I'd consider to be a case study – perhaps this needs a different title"*

*"I am not in a patient facing role but teach consultation skills. I found the wording around the case study biased towards patient facing roles but hopefully managed to adapt my response to show how my work can influence positive outcomes for patients. I think Standard 3 is of the utmost importance to the profession but wonder if the wording could be amended to help others like me"*

*"I'm strongly against the permanent addition of case studies to the CPD programme. It should be integrated as an optional suggestion for unplanned/planned entries but not forced as a separate thing"*

*"As a locum it is difficult to implement change other than to your own practice"*

*"I found this the most difficult to do. There was not guidelines [sic] as to what you were looking for"*

*“This was the hardest part of the pilot, and seemed, to me to be the least valuable. The task seemed very open ended, and more guidance about what is expected, both in terms of content and length, would be helpful”*

*“I have yet to complete the case study as this is the only part of the pilot that I have found challenging to get my head around”*

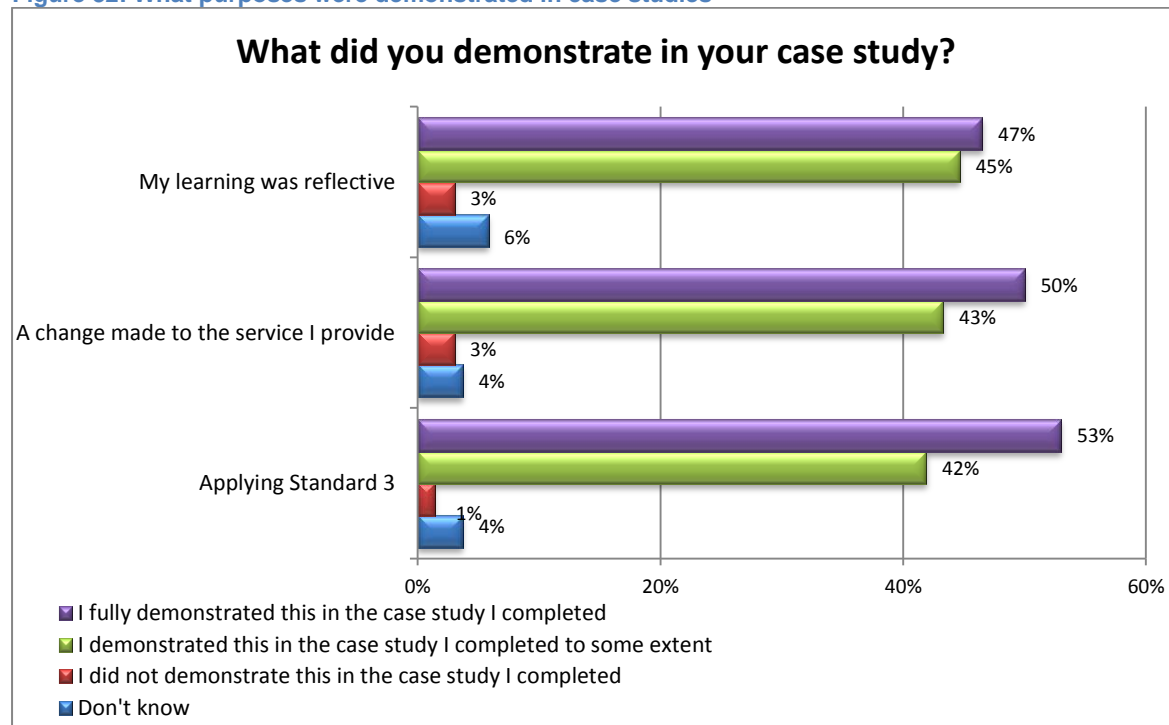
*“It was interesting to think about the different types of communication i.e. I used written communication”*

*“The case study is almost mandating a ‘success story’. I think that learning from mistakes is nearly as important as providing evidence of a successful change”*

Other outcomes noted were “Build self-confidence by reflecting on the positive outcomes of your activities. Encouraging you to do more in future to achieve positive outcomes and to be able to measure results”

When asked **what purposes they demonstrated in the case study they completed**, 432 participants responded (Question 51), and the results are shown in Figure 32 below. When asked whether they had demonstrated that their learning was reflective, 91% stated that they demonstrated this either fully or to some extent. 93% reported that they had fully or to some extent demonstrated an actual change made to the service they provided to patients or service users, and 95% stated that they either fully or to some extent demonstrated that they had applied the GPhC Standard 3, “Communicating Effectively”. This would suggest that these respondents had understood that these were the key factors which the GPhC wished to see demonstrated in their case studies.

**Figure 32: What purposes were demonstrated in case studies**



Source: SPH online survey, question 51

Fourteen respondents replied “Other” to this question, and added explanatory comments. These included the statement *“I did not realise that it was only Standard 3 that we were*





*supposed to be applying*”, suggesting that this aspect of the guidance was not clear to the participant.

Another comment stated *“My case study related mostly to written rather than verbal communication. The outcome was approval of consultant pharmacist post...I can only predict the impact this may have in the future”*. This suggests that the GPhC may need to be explicit in stating that communication to be demonstrated can be via any media or method. It also reflects the issue discussed elsewhere, that the impact of changes made may not be apparent for some time, which needs to be borne in mind when requesting examples of the impact of actions.

In addition, while in this example, the approval of a consultant pharmacist post may improve the service provided by the organisation to patients and service users, it is not clear how gaining this approval demonstrated how the individual improved the way they practice.

The GPhC may therefore also wish to be more explicit regarding how the case study should demonstrate improvements to the practise of pharmacy professionals. While the guidance appears clear, a change could perhaps be effective, such as asking people to describe “a change made to the way I provide my service to patients or service users”.

Another respondent stated that *“Without feedback it is difficult to know whether the case study was appropriately chosen (easy) and/or whether the above was demonstrated satisfactorily”*.

In response to Question 52, **“Did you experience any problems or issues when writing up your case study?”**, 54.4% of 417 respondents stated that they were not sure just what was needed, and 58.5% of the 419 respondents to the questions stated that they weren’t sure what a good case study looked like. One respondent suggested *“More guidance is needed for the case studies. Needs some more structure”*. Another stated that *“Of all the elements of the CFtP pilot, this is the one I am least sure of”*.

Further comments in response to Question 52 echoed that noted above about being unclear whether it had been completed satisfactorily:

*“When I compared with my colleague, I found that my case study was much more involved and time consuming which led me to believe I had overdone it somewhat.”*

*“I did not know how much to write and what level of detail plus was the case study good enough”*.

*“I would have spent longer on a more detailed case study, if there had been better guidance, but it felt so open-ended that I didn’t waste time doing something that felt like a chore, wasn’t helpful to me personally and may have been wrong”*.

*“I don’t know if my choice of case study was ‘technical or clinical enough’, need much more direction.”*

Other responses suggested that participants had not understood the GPhC’s requirements, suggesting that elements of the communication used may need to be revisited. For example, one participant stated:

*“I found it very difficult. Working in community as a lonely pharmacist for a multiple I cannot just start a service in my store. Also the examples were based on having enough time to carry out those services. Unfortunately as much as you would like you can’t spend 10 minutes in a consulting room with all patients e.g. all asthma patients showing them how to use an inhaler. Unless you have support from your employer I*





*felt a case study in community when you are the only pharmacist was very hard, hence why I had to choose one to help a colleague”.*

This raises two issues. One of these is that the communication Standard applies equally to working with all service users, including both colleagues and patients, and so choosing an example where the person was helping a colleague was entirely appropriate, although this does not appear to have been perceived as such. Also, the participant appeared to feel that the case study needs to reflect a more significant change in practice than is the case. This was also noted by one respondent to a different question (Question 62) who said:

*“In some fields being able to successfully carry out a case study can be extremely time consuming (especially in academia) relative to other fields such as primary/secondary care practice. I therefore think that case studies generally pose a disproportionate time/effort requirement on pharmacists working outside of “standard” roles.”*

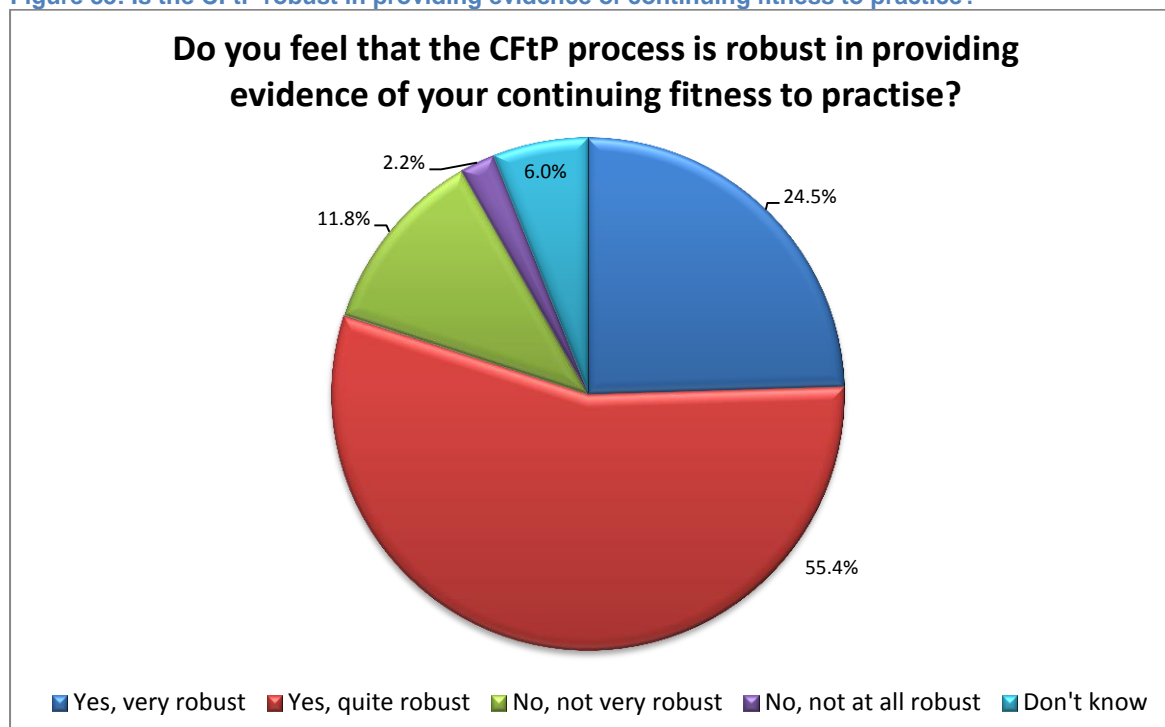
Another respondent stated that *“The main issue arises when you have to submit a case study which is not linked to a subject in planned or unplanned learning.”* It is suggested that the GPhC requirements around this, and their thinking behind it, are clarified in the guidance.

A significant issue appears to relate to the use of the term ‘case study’, as this can have precise but different meanings in different contexts. For example, one respondent stated *“I needed help in writing my case study as the last time I wrote one was nearly 10 years back when I was in University”*. Other respondents also appear to have assumed that the GPhC were asking for a *clinical* case study. In fact, they are asking for a real life example of a change to practice that pharmacy professionals have made which has had a positive impact on patients or service users. Communication around this is an important issue to address.

### **7.3.7 Outcome 7: The proposed approach is seen by stakeholders as providing assurance of fitness to practice**

Respondents were asked **whether they felt that the CFtP process is robust in providing evidence of their continued fitness to practice** (Question 61), As shown in Figure 33 below, 24.5% considered it to be very robust and 55.4% felt it was quite robust. 11.8% felt it was not very robust and 2.3% reported feeling it to be not at all robust. 6.0% recorded “Don’t know”.

Figure 33: Is the CFtP robust in providing evidence of continuing fitness to practice?



Source: SPH online survey, question 61

A number of additional comments were made, shedding more light on this. Some of these related to a need to evidence what has been recorded, for example *"I think it needs to be supported by some form of evidence e.g. notes of a meeting or peer discussion, attendance at a meeting,"* and the associated reliance on personal honesty, for example, *"It is still person based therefore I could write whatever I want with no check on the actual outcome."* One person commented that peer discussions made the process more robust, as *"you have to enter contact details of the person."* Others suggested that peers confirm that the conversation was held as described within the system.

A number of respondents noted connections with RPS Faculty membership, for example *"I think you should also accept achievement of the faculty as a means of showing CFtP because it is assessed by assessors and involves submission of peer testimonials. It took a lot longer to do and there should be some recognition from the GPhC for pharmacist who have already achieved Faculty membership"*.

Some respondents noted that the inclusion of peer discussions and case studies made the system more robust. Others suggested that a lack of clarity about how long or detailed entries should be made the process less robust. The number of entries was also questioned, for example *"I think it is very difficult in a few entries to ensure a robust process"*. The appropriateness of learning was also raised – *"[it does not] necessarily judge that you are doing the right CPD for your job role."*

Positive comments included *"the evidence provided is a small 'snippet' of my continuing fitness to practice and of course it would be extremely difficult to document all my development, however the format is much easier to complete - making the whole process much more enjoyable and engaging."* and *"It shows that learning activities have been carried out and shows your thoughts on the learning or incident to show depth of understanding"*.

### 7.3.8 Outcome 8: Peer discussions are robust and appropriate

As noted previously in Section 7.3.6 (Outcome 6: Participants understand the rationale for and requirements of the proposed approach), the majority of respondents (65.7%) reported in response to the question “**Who was your peer**” (Question 41) that their peer was a pharmacy professional from within their organisation. In 15.0% of cases the peer was a pharmacy professional from another organisation. In 11.3% of cases the peer was someone from a different profession within their organisation and 4.1% reported their peer as being a different profession from another organisation, suggesting that the type of peer was appropriate. Those who responded ‘Other’ to this question were asked to state who their peer was, and responses included a self-employed locum pharmacist, an HR partner from their own organisation, a GP and an optician, all of which also suggest an appropriate choice of peer.

Also demonstrated was that pharmacy professionals broadly understood the purposes of peer discussions.

Section 7.3.1 (Outcome 1 The proposed approach is simple to use) showed that the majority of respondents (74.3%) found it very easy or quite easy to identify a peer (Question 40). However, 19.1% found it either very or quite difficult, and 6.7% did not undertake a peer discussion. Reasons for this included:

- being unable to find a suitable peer
- working across several settings
- having recently changed roles
- working on their own, for example from home
- lack of time
- concern about the time required
- discomfort with the nature of the type of discussion
- potential sensitivity of the subject matter

For example:

*“I work across several teams and have 3 distinct roles. Hence I was unable to find someone who had the time or the experience to help support my CFtP entries.”*

*“It is impossible to find someone to team with you when you work on your own.”*

*“There were issues with regards to my situation at work; I had moved branches and mid-way through this process my pharmacy received a Poor inspection that had to be dealt with.”*

*“I didn't undertake a peer discussion, because I was concerned about the time it would take for the peer to provide feedback, and I felt uncomfortable about discussing the concept of peer discussion with my colleagues. Although it is something I do regularly, I am not used to recording / formalising the discussions through CPD, as it is a new concept.”*

*“It was more difficult considering what subject / behaviour /topic was to be discussed with my peer.”*

Such barriers should be considered by the GPhC, to identify if any further support can be given to pharmacy professionals in helping ensure they are able to identify appropriate peers.

Section 7.3.1 (1) Outcome also explored **how easy it was for participants to identify and area or topic for each of the entry types** (Questions 33, 36, 40, 42) and showed that this was very or quite easy for 94% of respondents for planned entry types, very or quite easy for 88% of respondents for unplanned entries, very or quite easy for 77% of respondents for peer discussions and very or quite easy for 52% of respondents for case studies. 17% of respondents reported that it was not very easy or very difficult to identify a topic for a peer discussion. This suggests that peer discussions could be made more robust if participants had improved guidance as to possible appropriate peer discussion topics, for example through a wider range of example entries.

While the majority of peer discussions took place in working hours in response to the question **“Did your peer discussion take place during or outside working hours?”** (Question 44), 23% of respondents reported that the discussions took place outside working hours. This may present a practical barrier to participation, making this part of the process somewhat less robust.

As discussed in Section 7.3.4 (Outcome 4: The proposed approach incurs negligible additional time and other costs), while the majority of respondents, 81%, noted that their peer discussions took five hours or less to complete, including time taken to identify a peer, make arrangements etc. as well as the discussion itself (Question 46), 14% of respondents stated that they took between 6 and 15 hours, and for 3% of respondents they took over 15 hours. This may also present a practical barrier to participation, which the GPhC may be able to address through improved guidance to participants, and other support such as assistance in identifying peers.

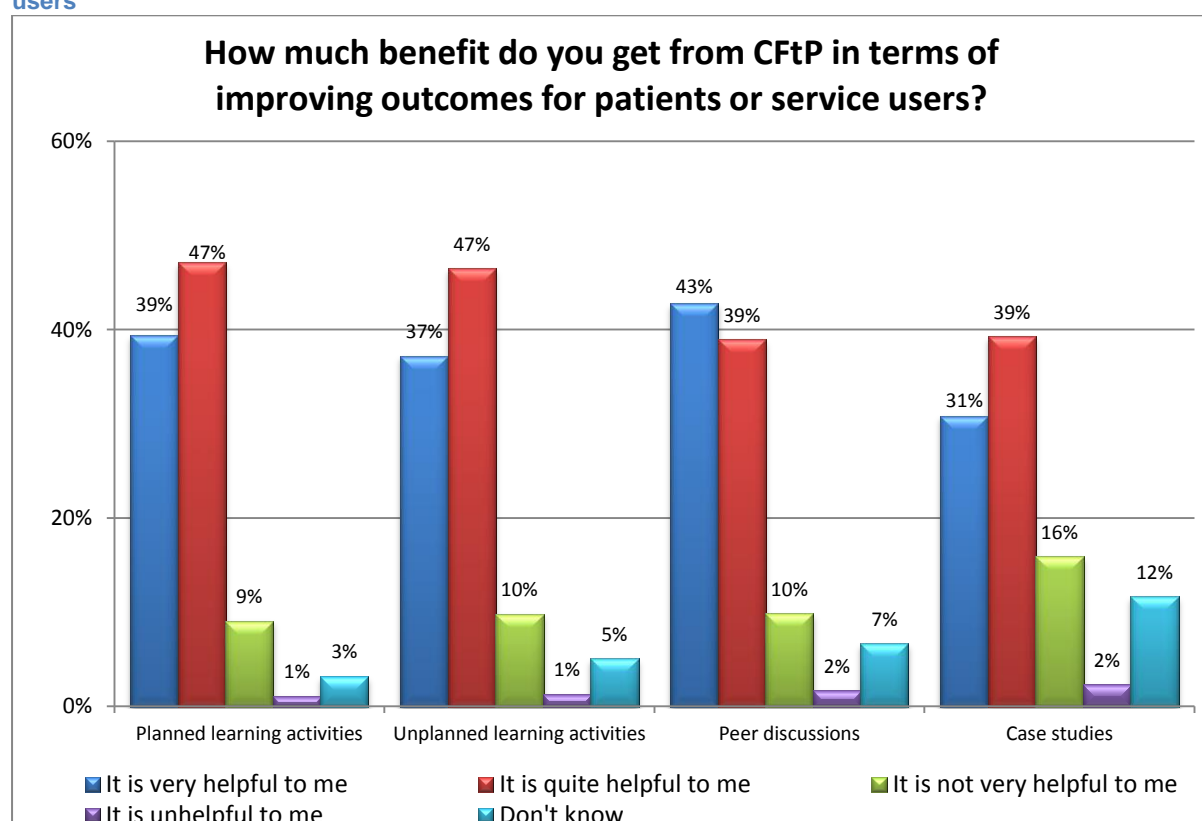
When asked **whether their method of carrying out their peer discussion had worked well, and whether they had been able to have a full and open discussion, with enough time** (Question 45), the 92% of respondents reported that it had worked very or quite well, suggesting that the discussions held were robust in achieving the aims of the GPhC.

### 7.3.9 Outcome 9: Each element of CFtP meets its’ objectives

Respondents were asked **how much benefit they got from the CFtP system in terms of improving outcomes for patients and service users** (Question 56). The results are shown in Figure 34 below. This shows that for planned learning, unplanned learning and peer discussion respectively, 86.6%, 83.7% and 81.7% of respondents felt that CFtP was very or quite helpful to them in improving outcomes for patients or service users. The figure for case studies was lower, at 70.1%.

For planned learning, unplanned learning and peer discussion respectively, 3.2%, 5.1% and 6.7% of respondents replied “Don’t know”, whereas for case studies the figure was 11.7%.

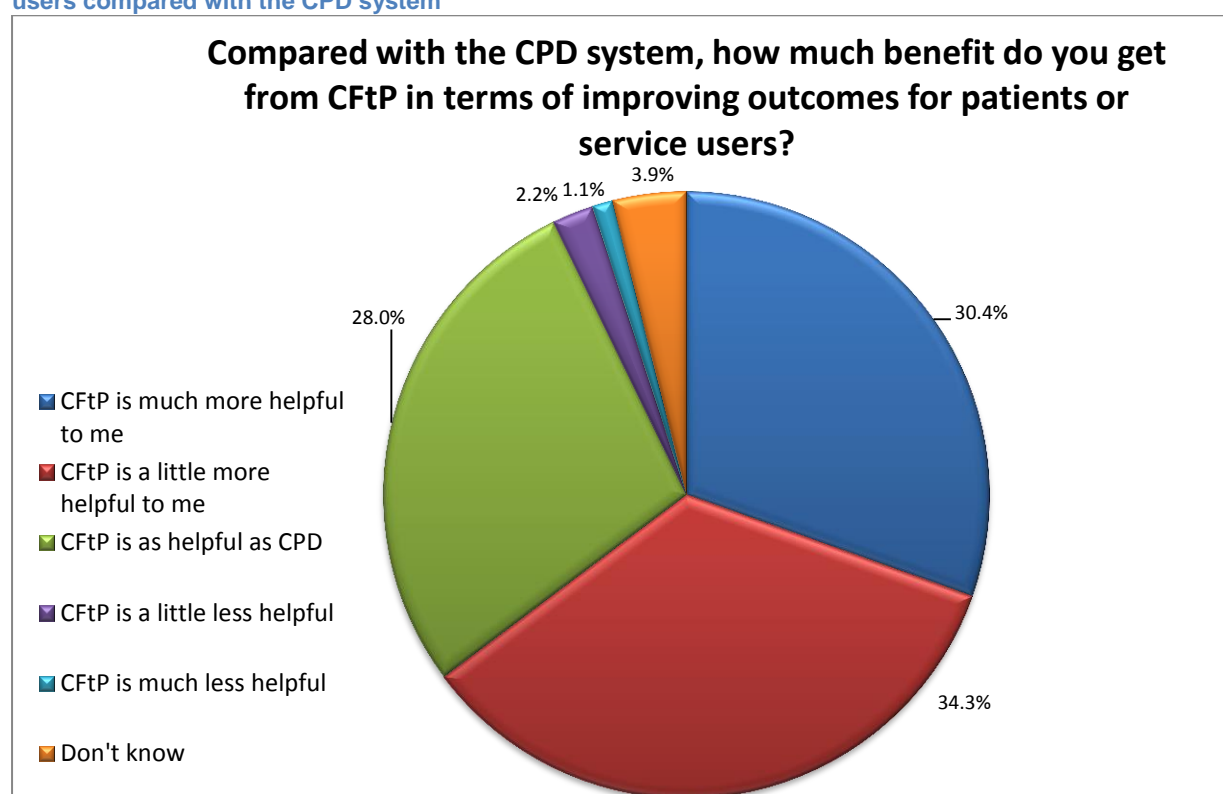
**Figure 34: How much benefit CFtP system gives in terms of improving outcomes for patients or service users**



Source: SPH online survey, question 56

Compared with the current CPD system, 30.4% of respondents felt CFtP to be much more helpful in terms of improving outcomes for patients or service users (Question 57), and 34.3% felt it to be a little more helpful. 1.1% felt it to be much less helpful, as shown in Figure 35 below.

**Figure 35: How much benefit CFtP system gives in terms of improving outcomes for patients or service users compared with the CPD system**

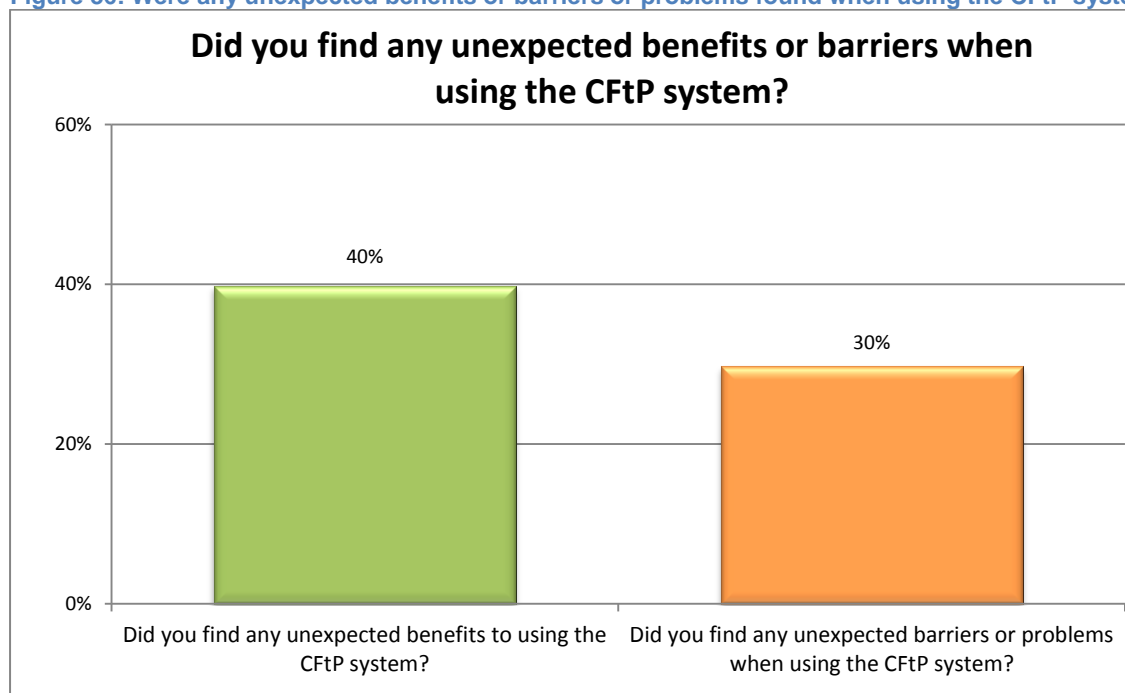


Source: SPH online survey, question 57

### 7.3.10 Outcome 10 Any unexpected consequences are identified

The survey asked **whether respondents had found any unexpected benefits to using the CFtP system** (Question 59) or any unexpected barriers or problems (Question 60). When asked about barriers, they were requested not to identify technical issues such as software versions, firewalls etc. as these would relate to the software used for the pilot, which will be replaced in any final version. As shown in Figure 36 below, 39.8% of respondents reported that they identified unexpected benefits, and 29.7% reported that they had identified unexpected barriers or problems.

Figure 36: Were any unexpected benefits or barriers or problems found when using the CFtP system



Source: SPH online survey, questions 59 & 60

In both cases, they were asked to describe these. With regard to problems and barriers encountered, a large number of responses related to technical issues with the software used, which will be replaced in any final version. Some themes within these did emerge however, and the GPhC may find it helpful to ensure that they are addressed in a final version. These were primarily:

- Not having the ability to review or edit entries when submitted
- Not having any prompts or reminders of instructions on the relevant page
- Difficulties in using the system both at home and at work

Other comments reflected issues raised elsewhere, such as those below:

*“The case studies. I don’t know if I did it right?”*

*“Difficult to identify a peer for discussion and also very difficult to identify a topic for a case study. I felt GPhC would accept given my role is mainly head office based now”*

*“Peer discussion was nearly impossible. Finding the appropriate length of time to hold a discussion with a colleague and an appropriate topic. Time was an immensely difficult part of the CFtP”*

*“I did find some of the wording very biased towards patient-facing pharmacy roles and it sometimes took some thinking to work out how I could apply the principles to my own role in teaching. This was mainly in relation to the case study”*

*“Many people encounter time as a direct issue to CPD entries in the original system. Fortunately you can start and stop many forms of learning on your own flexible schedule for the most part. Peer discussion you cannot. It is very difficult to set aside time for two professionals to have a meeting to discuss something outside of work. During work is very likely to be impractical to achieve in certain sectors such as community pharmacy”*





*“The whole system is geared towards activities for pharmacists who are in patient facing roles. I am not so found it difficult to shown how my activity in a commissioning organisation directly affected patients”*

*“Just the newness of it and not fully understanding what was expected of me in each type of example”*

*“Difficulty in finding an appropriate peer for discussion and also an appropriate case study to use”*

*“I thought it was unexpectedly very easy in many ways and not challenging enough for pharmacists working at an advanced level of practice compared to other ways of recording such as the RPS Faculty portfolio”*

*“I used to record CPD that was beneficial to my job role but may not have necessarily had an obvious benefit to patients...I did not feel that I could record any of this type of CPD on the CFtP system”*

*“Carrying out CPD hinges on the good will of family to attend courses and carry out e-learning as they all cost personal time and are carried out without financial reward”*

*“I could not always include examples of how learning had benefitted service users as benefits will not always be immediate”*

215 comments were received describing unexpected benefits to using the CFtP system. Many of these fell into a number of distinct themes, which are exemplified in the quotes below, taken from some of these comments. In the majority of cases, benefits described align with the changes the GPhC are aiming to achieve through CFtP.

*“Easier to follow and quicker to complete”*

*“Much more intuitive”*

*“Simpler recording system enabled me to focus on the important elements of my reflection, learning and benefits, without seeing the recording system as a chore in itself”*

*“I really enjoyed it”*

*“It made me focus my learning”*

*“Improved buy in to the process as I like the simplified entries and it feels more personal, worthwhile, focused”*

*“Helped me better organise my thoughts”*

*“It helped me really focus on the pharmacy standards”*

*“I found writing it up as CPD took much less time than before. This meant that I was more likely to write it up soon after finishing it”*

*“Saved time, allowed for more reflective learning”*





*"I found the peer discussion really very helpful, and will hopefully do this again...I gained insight and got ideas for practice and development that I wouldn't otherwise. I also really enjoyed the case discussion [sic]. I enjoyed reflecting on this and found over time I was able to build on this"*

*"Actually wanted to make the record!"*

*"Writing a case study was rewarding in terms of reflecting on benefits to service users"*

*"Free writing enabled me to better express my learning experience"*

*"Much quicker"*

*"It was much more enjoyable and satisfying to write up the entries. The old CPD system always felt like a chore and not relevant to my practice. The new system seems more relevant and more thought provoking"*

*"The peer discussion really did help me reflect on my work and actions taken to a greater extent than I had expected. I hadn't looked forward to doing this piece of work but overall it was probably the most useful part of the pilot"*

*"Far more flexible to allow me to capture... more unconventional types of CPD"*

*"The case study made me realise that we often make changes without reflecting on them and how they have worked out"*

*"As I am in a non-patient facing role, the new CFtP process dovetails much more closely with the work that I do"*

*"I really like the flexibility in just being able to write down a reflective account of what was done and how it benefitted"*

*"I am self-employed and work from home so don't routinely get the opportunity to talk to colleagues about my practice. Putting aside the specific topic we discussed for the CFtP pilot, the peer I talked to (who is in a similar situation to myself) and I both enjoyed a much more wide-ranging discussion about a number of areas of practice. We both agreed we should do it more often"*

*"It was a real confidence booster to undertake the peer discussion"*

*"I felt I had more ownership of my professional development"*

*Examples of benefits not previously described as anticipated by the GPhC are shown below:*

*"Chatting to others on the pilot elicited more professional discussion and reflection on what I was part of"*

*"Able to describe to colleagues about the pilot, ease of use, timeframe for change etc."*

*"Useful to...challenge myself"*

*"We have now set up regular peer discussion sessions which the whole team will participate in"*

*"It creates a more varied and valuable portfolio"*

### 7.3.11 Others ways in which the CFtP system could be improved

In the online survey, the opportunity was taken to ask a final question, **“Do you feel that there are any ways in which the system could be improved, to make it of more value to you and patients / service users?”** (Question 63). Many of the responses reiterated points made in earlier questions are reflected above. However, a number were new, and these are shown here.

*“Possibly be clearer where evidence is required. I was unsure when I had to evidence or reference things”*

*“A matrix to show entries and their stage of completion. This could be continually updated and be available for peer review at any point”*

*“A reminder email can be sent to individuals on a monthly basis to record their entries”*

*“Some kind of voluntary discussion forum where people could put requests for information or ideas to help with case studies and peer discussions”*

*“Some means of recording the date activity took place”*

*“Index of learning records completed for my individual account”*

*“Access through a smartphone app where notes can be made and written up at a later date, possibly syncing with outlook calendar”*

*“The ability to review and develop objectives for the coming year, then work to complete them”*

*“It needs to be linked to appraisal systems so that employers can see benefits”*

*“Link to the RPS Faculty as this provides assurance to patients”*

*“Minimum quantity of words in each section”*

*“Rather than having to complete a certain number of entries per year, ... have a shorter timescale to encourage regular reflection”*

*“More case studies”*

*“An optional box for learning notes to allow users to go back and look for information they learned if needed without having to research it again at the original source. Some kind of app for training websites to integrate into allowing them to input information from the training into the relevant boxes on the CPD system”*

*“For each entry perhaps needs a question about what you will do in the future to ensure knowledge is kept up to date and to emphasise that this is a continuous process”*

*“A summary of the review each year which could be presented as a certificate so is visible in your appraisal folder and also in your workplace for patients to feel confident about your practice”*

*“Points system for CPD”*



*“Proper 360 degree feedback requirement on a 5 year cycle”*

*“Having less sections to complete to make writing up more user friendly”*

*“More in depth feedback, not just on process but the content”*

*“If we could nominate a peer who would automatically receive a summary of CPD entries, e.g. a line manager or chief pharmacist, so that they can be assured that appropriate CPD is being completed annually”*

*“Make the peer review and case studies... at users discretion”*

*“Linking it to the clusters and competencies of the Advanced Pharmacy Framework”*

*“It should be a dynamic system so as to be able to accommodate any changes in the way we work in future”*

*“I don’t believe that CFtP should be linked to my appraisal. My line manager ... is likely to abuse/misuse the privilege...it would stop me being as candid”*

*“A reward at the end of the year such a sticker to congratulate you on completing the CFtP entries”*

*“Fitness to practice interviews to be held every 5 years”*

*“Made to simulate a portfolio”*

*“The question around benefit to be changed to allow description of how it makes one better in one’s professional role, as well as how it may benefit service users more explicitly”*

*“Develop a forum, where examples can be discussed. Use of social media to share experiences. Patients may not be aware that pharmacists have to show evidence of CFtP and again, education of patients/service users may be useful. My GP colleague was not aware that the GPhC put so much emphasis on CFtP”*

## **7.4 Conclusions and Recommendations**

A range of questions were asked which sought to understand if and how pharmacy professionals had changed their attitudes and / or behaviours, to achieve the overarching aims of the proposed CFtP framework, and what factors may have acted to support or be a barrier to this.

In terms of encouraging participation, the majority of pharmacy professionals consider learning and development to be essential or important to their roles, which is an important building block.

When asked about how easy it was to find learning and development opportunities which could be reflected in the CFtP system, it was found that, as may be expected given that they are already familiar with these types of entries, it was easiest for participants to identify planned and unplanned learning opportunities than to identify case studies and peer discussion topics. It was more difficult for them to find appropriate case studies than peer discussion topics.



The GPhC wishes to encourage pharmacy professionals to record learning activities closer to the time these activities take place. More participants recorded learning activities within 3 months of the activity taking place in the CFtP system than the current CPD system (68% compared with 46%). While pilot participants had less time in which to complete entries (April to December 2016 rather than a full year), a number of comments received suggested that participants were encouraged to make their entries earlier by facets of the proposed framework, especially its speed and ease of use, and the ability to record a narrative rather than feeling like they were 'ticking boxes'. *It is recommended that these findings are communicated in future iterations of the framework, to encourage engagement.*

The encouragement of greater reflective learning is a key aim of the proposed framework, and 60% of respondents stated that their reflection had been a little or much more reflective than had been the case in the current CPD system. When asked to consider potential barriers to reflective learning, a higher percentage had been able to think of ways to apply their learning to their work (93%) than had had enough time to consider what they had learnt or been made aware of during learning activities (85%) or than had had enough time without distraction to think through what their learning or development needs are (74%). This may affect their ability to identify planned learning needs and appropriate topics for peer discussion in particular. It may also impact on their ability to identify an appropriate case study to use.

It is anticipated that participation will be enhanced were pharmacy professionals see benefits to their fully engaging with the CFtP process. When asked about different facets of this, the majority of respondents felt that all entry types were helpful to them in improving their practice, with the greatest benefit being identified for planned learning, unplanned learning and peer discussions. 12% reported that they felt the case studies to be unhelpful. A similar picture emerged when respondents were asked how much benefit they got from CFtP in terms of their own professional development. *This suggests that the potential benefits of the case studies may need to be more clearly articulated by the GPhC.*

A further aim of the proposed framework is to encourage participants to demonstrate a positive impact on the service they provide to patients or service users, and the majority reported that they were able to do this for all or some entries.

A number of respondents reported that the peer discussions were very useful, and in some cases, this was unexpected. There was good recognition of benefits of peer discussions which the GPhC had hoped to encourage. *The GPhC may wish to use these findings to help address potentially less positive preconceptions of the benefits of these discussions as they go forward.*

There was a perception among some participants that peers should be pharmacy professionals, with equal technical knowledge to their own. *This suggests they may not have fully understood the guidance, and the GPhC may benefit from reviewing this guidance.*

When looking at barriers to participation, the entry type which caused most difficulty for participants was the case study. There was an element of confusion around the term, with some respondents noting that they had thought this meant a clinical case study. Problems reported included not having a good example to use (18% of respondents), not having enough time to complete it as fully as they would have liked (14%), not being sure what a good case study would look like (58%), and not being sure just what was needed (54%). However, the majority who completed a case study reported that they demonstrated the key elements being looked for by the GPhC to at least some extent. With regard to the need to demonstrate an improvement in practice related to communication, number of respondents felt that this needed to relate to communications with patients rather than patients or service users. The same issue arose in demonstrating the impact of any changes made to practice.



In addition, fewer respondents found the guidance given for case studies and the peer discussion clear, with the case study and peer discussion guidance viewed very similarly.

As this is a new and unfamiliar element, it would be expected that participants would be less clear about requirements than for planned and unplanned learning, and it does appear that there was a lack of clarity among participants about some aspects. While it is not possible to identify the extent to this is because these elements are new, the Communications section at the start of this report in particular explores the clarity of the guidance given by the GPhC. From information gained via the online survey, *it is recommended that the term 'case study' is reviewed, and potentially replaced by a term which is less likely to be confused with a clinical case study. It is further recommended that guidance around case studies is reviewed to address the issues raised here.*

The use of different tenses for planned learning entries was found confusing by some. *The GPhC may wish to consider reviewing their guidance around this.* A technical issues which arose within the pilot system meant that users found it difficult to go back to amend entries, which also made it difficult for participants to record a planned learning activity, then later return to shown the impact this had on their service, which it is assumed will be addressed in future iterations.

It is also important to the GPhC that the proposed framework does not impose additional costs to users. The principle cost to participants is that of their time. For both planned and unplanned entries, respondents reported that it took less time to complete these entries compared to the current CPD system, with 29% reporting that planned entries took a lot less time, and 26% reporting that unplanned entries took a lot less time.

In addition, some participants had difficulty in identifying a peer and/or appropriate topic for their peer discussion. Improved guidance around this is suggested.

When asked how long peer discussion entries took, including all aspects such as planning, arranging a time etc., 35% took less than 2 hours, and 45% took between 2 and 5 hours. 3% took over 15 hours. This is a significant use of resource. The GPhC may wish to consider ways to help participants reduce the amount of time taken. *Suggestions include providing summary guidance for peers to reduce time needed by participants to explain this; prompt sheets for participants of issues to consider in planning their discussions; a proforma which participants can use should they choose to record their discussion; more examples of peer discussions relevant to different settings to clarify expectations*

Case study entries took less time on average, with 67% being completed in 1.5 hours or less, although 9% took over 3 hours. Again, this length of time could potentially discourage participation. *It is suggested that the GPhC provide more examples for participants of case studies, relevant to different settings, and review the guidance provided. The GPhC may also wish to give a recommended maximum time that people should spend on both case studies and peer discussions, to help set expectations.*

The level and type of support offered by employers was explored as this could affect levels of participation and engagement, acting either as a barrier or to act to encourage participation. It should be noted however, that many issues around this will be independent of the framework used.

64% of respondents reported that they were allowed sufficient time in their working hours to complete records on the CFtP system, and 77% said that they completed their peer discussion in working hours. Both of these may have implications going forward both in pharmacy professional's participation and the latter may have an effect in engaging with



potential peers. *The GPhC may wish to communicate this with employers to raise awareness of this.*

Given that many respondents complete a significant amount of the recording of learning activities takes place outside working hours, affecting their work/life balance, and that such activities carried out at work will affect the other demands on their time, it is particularly important that the gains identified in reducing the time taken to complete planned and unplanned entries are not outweighed by the additional time required for some of the peer discussion and case study. The impact for employers of any additional time taken, potentially both for participants and employees acting as peers, needs to be considered.

This is also important in achieving another aim of the GPhC, in encouraging pharmacy professionals to view CFtP as a normal part of their working life, and not an add-on.

It is important that the framework is considered to be proportionate, with the time and resources required matching the assurance it gives in pharmacy professional's fitness to practice. The majority of respondents reported that they felt the system is proportionate, with roughly equal numbers feeling it should demand either more or less effort.

Similarly, it is important that the framework is considered to be robust, and the majority reported that they felt it to be robust, with 76% thinking that it is very or quite robust, although 12% considered it to be not very robust. A number of comments were made to expand on these views, including the opinion that evidence should be requested of information entered. A number of comments were made to suggest that the peer discussion and case study elements made the proposed framework more robust. *It is suggested that the GPhC communicate the positive feedback received considering the robustness of the proposed framework and the assurance it provides, monitor future feedback on this and consider the advantages and disadvantages of further reducing the reliance on trust in the future.*

Unexpected benefits or barriers to the framework were explored. More benefits than barriers were reported, and a number of positive comments were received which demonstrated that behaviours and attitudes towards the proposed framework were in line with those intended by the GPhC. The majority of barriers related to technical issues related to the software used, which will be replaced. *It is recommended that the GPhC review all these comments (provided separately), to be able to address them in new system iterations, and to help inform future communications.*

It is also important that the framework is equally accessible and useful to all sections of the pharmacy profession. While participants were not asked about this directly, an analysis of findings by characteristic is given. No clear trends emerge from this of particular groups being advantaged or disadvantaged systematically, although some findings are of interest relating to specific areas. *It is suggested that the GPhC review this in detail to inform their future communication strategies.* A number of comments were made which did touch on issues of fairness and equity. Some of these were around differing amounts of free time available for carrying out and recording learning in different settings, and the actual or potential impact of carrying out learning and recording on people's work/life balance.

A number of respondents made comparisons with and suggestions relating to the RPS Faculty system. It is suggested that these views are acknowledged in future communications about the CFtP framework, perhaps as part of a Frequently Asked Questions section.

## 8 Analysis of Database Entries

### 8.1 Methodology

The Continuing Fitness to Practice database entries consist of four activity types: planned learning, unplanned learning, peer discussion and case study. The analysis has been undertaken on a representative sample for each activity type, from across the time period of submission (April-December 2016). Each sample reflects the balance of characteristics of the total sample, in relation to; job role, gender, ethnicity, workplace setting, country, and whether the participant worked full-time/part-time. Around one hundred entries have been scored for each activity type (95-108). The sample size is determined by the point at which data saturation is reached (no new themes arising).

Each activity requires the participant to address a particular question, and this is supported by additional points to address, detailed in the guidance provided to participants (see Appendix 4). Each entry has been scored based on how well the question was addressed, and whether the relevance, impact and benefits of the learning and development activities, are clearly indicated in the answer. The initial analysis for each activity is discussed below.

#### 8.1.1 Quality Assurance

10% of scored entries from each activity type were double-scored independently by a second reviewer. Inter-rater reliability was very good; the majority of component scores either completely matched, or differed by a single point, leading to very similar overall scores for each question. Only one instance of a score differing by 2 points occurred (i.e. a zero vs two), and this was resolved through discussion. This is reassuring because ostensibly an assessment of, for example, whether a description is “detailed and clear”, is somewhat subjective, however, the Quality Assurance (QA) process suggested that these assessments were reproducible.

Following the main analysis of database entries received between April and early December 2016, we conducted a rapid analysis of entries made between December 5<sup>th</sup> 2016 and January 10<sup>th</sup> 2017. A selection of ten entries from each activity type was scored to assess consistency with previously analysed entries. The selection process ensured even spread throughout this time period (i.e. every 30<sup>th</sup> entry when a further 300 entries had been received for the activity).

Although the data is limited, no major differences were observed between the main analysis and these late entries. The key finding regarding documenting hypothetical benefits/impacts rather than measured benefits was observed. The need for further instructions to ensure participants document the relevance of the learning and development activities; the learning outcomes; and reasons for choice of peer, was also corroborated. Analysis by demographic sub-groups was not conducted due to small numbers.

The GPhC questions 1-3, 7 and 10-11 refer to personal details or uploaded files, and have therefore not been analysed. The learning and development entries are responses to questions 4-6, 8-9 and 12 & 13, as illustrated in the table below:

**Table 19 Guide to questions that pilot participants answer in their online entries**

Question number	Detail
1-2	Personal details
3	Type of learning and development
4-6	Planned CPD – analysed
7	File upload – no question
8-9	Unplanned CPD – analysed
10	File upload – no question
11	Peer's personal details
12	Peer discussion CPD – analysed
13	Case Study CPD – analysed

## 8.2 Planned Learning Entries

Planned learning is defined by GPhC as “an activity designed to develop knowledge and or skills, that is planned in advance of undertaking a learning activity.”

### 8.2.1 Planned Learning entries analysis methodology

Participants were required to answer three questions as part of this entry:

- Question 4. What are you planning to learn?
- Question 5. How are you planning to learn it?
- Question 6. Give an example of how this learning has benefited your patients or service users

As directed in the guidance for participants (see Appendix 4), the first question was assessed according to:

- a) the presence of a specific learning objective
- b) an explanation of relevance to the participant's role
- c) how the learning will affect patients or service users

The second question required the participant to give details of the learning activities, and was scored on the level of detail given.

The third question was assessed according to:

- a) the presence of an explanation of how the learning from the activity had been applied in practice
- b) an example of how the learning benefited patients (or service users) (as outlined by the guidance)

### 8.2.2 Planned Learning entries analysis findings

#### (1) Analysis of entries for Question 4: What are you planning to learn?

In answer to the first question, the vast majority (71%) of participants gave clear and specific learning objectives in their entry. Twenty-five percent gave an indication of objectives, but provided very little detail; for example, a one-line statement of the topic of learning. Only a few entries (4%), failed to give any indication of objectives.

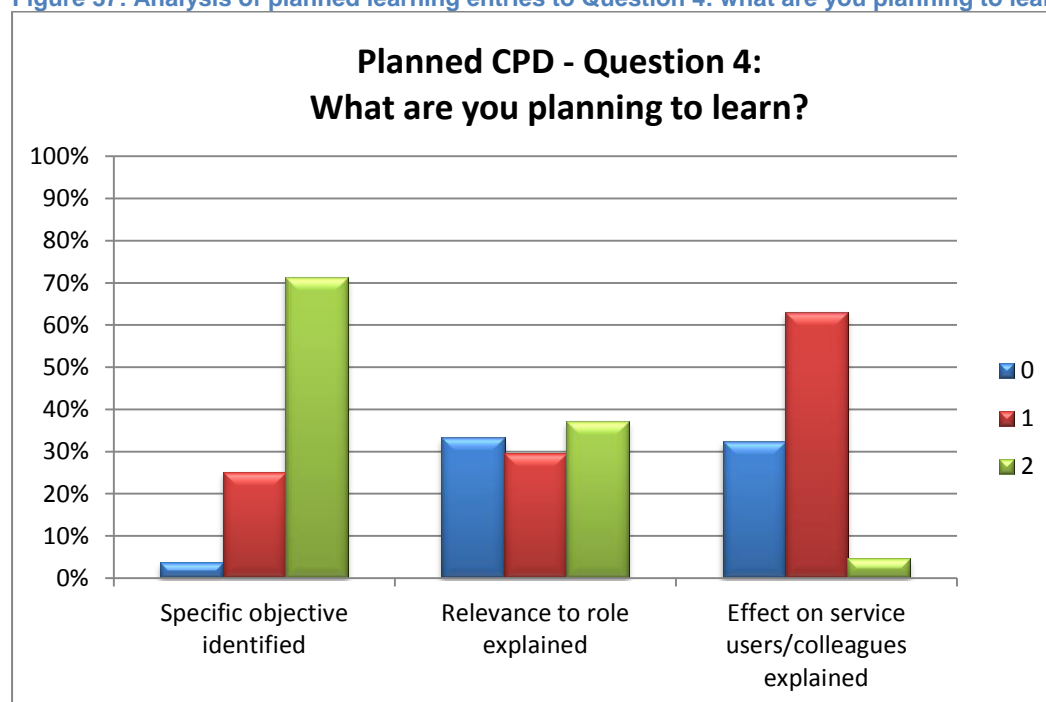


The relevance of the learning activity was less well explained; 37% gave clear and specific reasons for the relevance of the activity; 30% explained some less specific relevance; however, 33% of entries failed to give any explanation for the relevance of the activity to their role. This may point to the need for clarification regarding the choice of learning and development activities and greater guidance to ensure participants are documenting activities with a direct relevance to their work. For example the question could say “What are you planning to learn and why?” or “What are you planning to learn, how is it relevant to your role and how will it affect patients / your clients?” Alternatively, participants may be failing to document relevance as they may assume this is inferred by their job title.

Likewise, the impact of the learning was not well documented. Five percent of participants gave a specific example of the impact of learning in practice in answer to question 4, which was the desired response. The majority of participants failed to give clear and specific impacts of the effects of their learning on service users or colleagues, in answer to this question. Sixty-three percent reported hypothetical or expected impacts of the learning gained, but no measured impact was observed. Thirty-two percent did not explain the impact/potential impact at all. This may indicate that many participants are documenting their CPD activities before implementing the learning gained. In which case, if measured impacts are required by the CPD assessors, clarification on the timing of CPD entries may be required. Alternatively, many participants documented impacts in response to Question 6, suggesting that it may not be necessary to expect this information in the answer to question 4.

Figure 37 below shows the results of the analysis to date of entries to Question 4.

**Figure 37: Analysis of planned learning entries to Question 4: what are you planning to learn?**

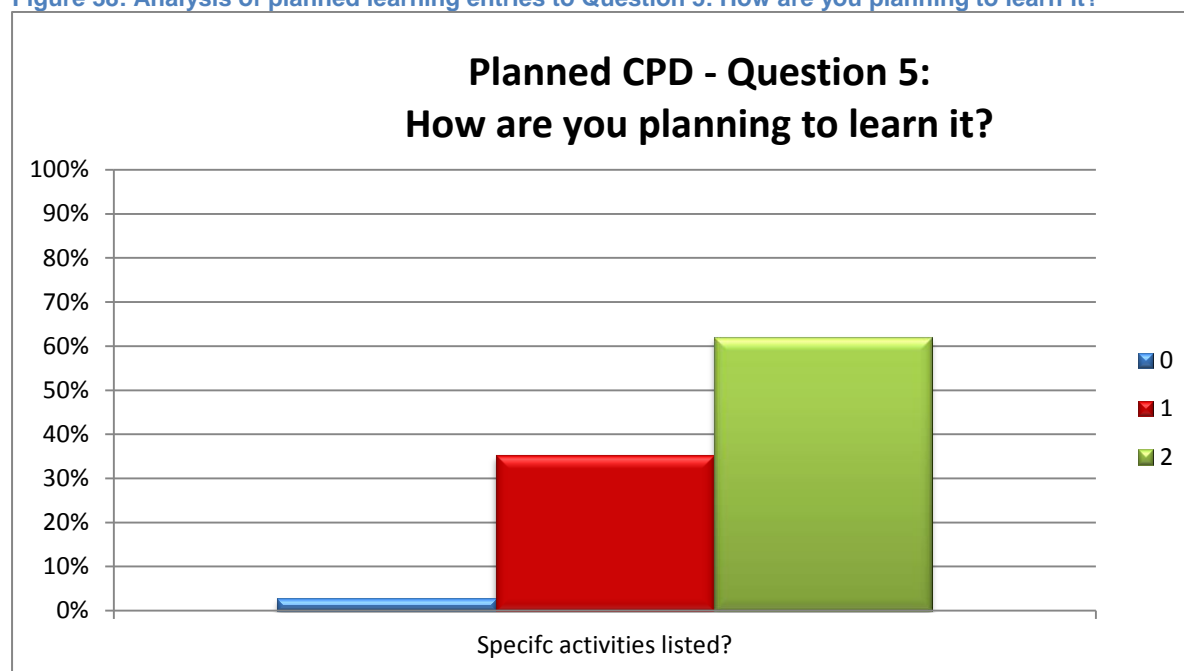


- a) Specific Objective? (Score: 0 no clear objective identified; 1 some objectives; 2 clear and specific objective identified)
- b) Relevant to role? (Score: 0 relevance not explained; 1 some relevance; 2 clear and specific relevance explained)
- c) Anticipated Effect on service users/colleagues? (Score: 0 no clear impact explained; 1 implied/expected impact; 2 impact demonstrated)

## (2) Analysis of entries for Question 5: How are you planning to learn it?

Almost all participants gave details of a specific activity to support the learning objective. The majority gave full explanations, with examples of several types of activity (62%). However, some (35%) gave limited detail or only one activity, for example: '*Attend multidisciplinary educational meeting*'. Figure 38 below shows the relative scores attributed to these entries.

Figure 38: Analysis of planned learning entries to Question 5: How are you planning to learn it?

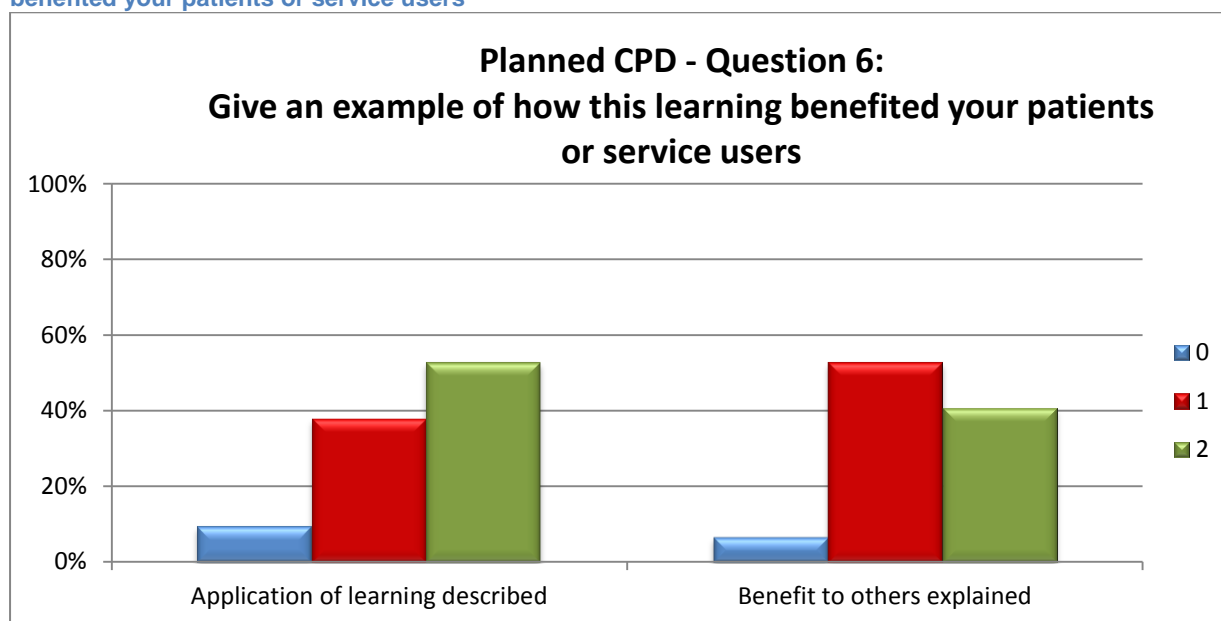


Specific activities listed? (Score: 0 no activity listed; 1 some activities/ little detail; 2 several activities listed)

## (3) Analysis of entries for Question 6: Give an example of how this learning has benefited your patients or service users

The vast majority of participants described some application of learning; either an explanation of how learning might benefit patients/colleagues (38%), or in addition clear actions taken as a result of learning (53%). Many of the participants, who failed to describe the benefit to others in response to Question 4, did give some examples in response to this question. Overall, some benefit to others was described by almost all participants; 94% (either anticipated (53%) or demonstrated (41%)). This is illustrated in Figure 39 below.

Figure 39: Analysis of planned learning entries to Question 6: Give an example of how this learning benefited your patients or service users



- a) Application of learning described (Score: 0 no application of learning (actions taken) described; 1 understanding of how learning could be applied/hypothetical; 2 clear actions taken as a result of learning).
- b) Example of benefits to others given (Score: 0 no example given; 1 understanding of benefit/hypothetical example; 2 clear real example of benefit)

### 8.2.3 Planned Learning entries recommendations

- Further clarification and guidance regarding the choice of CPD to ensure participants are documenting activities with a direct relevance to their work.
- Further instructions for participants to explain the relevance of the CPD to their role
- Impacts of the CPD are best addressed in response to Question 6 rather than Question 4 (which invites participants to describe a future activity: 'What are you planning to learn')
- The timing of CPD entries may need clarification if measured impacts are to be documented (i.e. entries made once impacts have been realised). Alternatively, multiple entries could be required (i.e. at the time of learning, at implementation of learning and following implementation) in order to assess learning and impacts

See Appendix 7 for two good examples.

## 8.3 Unplanned Learning Entries

Unplanned learning is defined by GPhC as “the occurrence of an unplanned event that causes a learning activity”

### 8.3.1 Unplanned learning entries analysis methodology

Participants were required to address two questions as part of this entry:

- Question 8: Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills
- Question 9: Give an example of how this learning benefited your patients or service users

As detailed in the guidance provided to participants (see Appendix 4), the first question was assessed according to the presence of:

- a) a clear description of the event or activity, and
- b) a description of what had been learnt

The second question required the participant to give details of

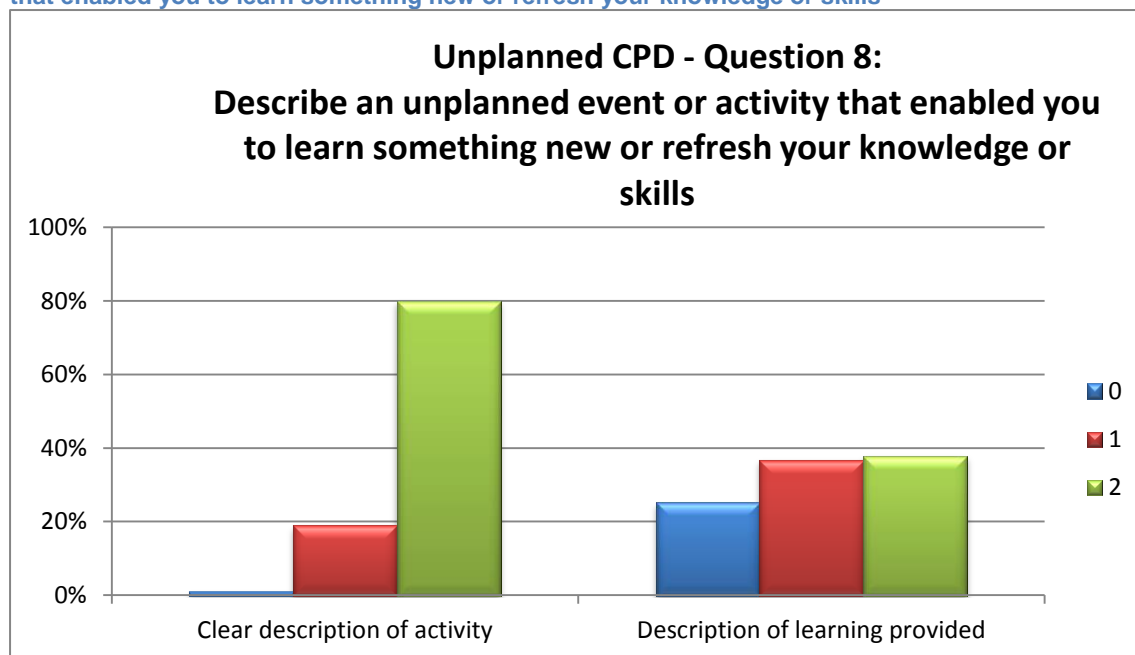
- a) the application of learning (actions taken), and
- b) how this had benefited patients/colleagues.

### 8.3.2 Unplanned learning entries analysis findings

- (1) Analysis of entries for Question 8: Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills

All participant entries gave some description of the event or activity for their CPD. The vast majority gave detailed and clear descriptions (80%), whilst some were more limited (19%). Most participants gave some description of the learning gained from the activity (75%), with 38% of these giving more detailed descriptions of learning outcomes (see Figure 40 below).

**Figure 40: Analysis of unplanned learning entries to Question 8: Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills**



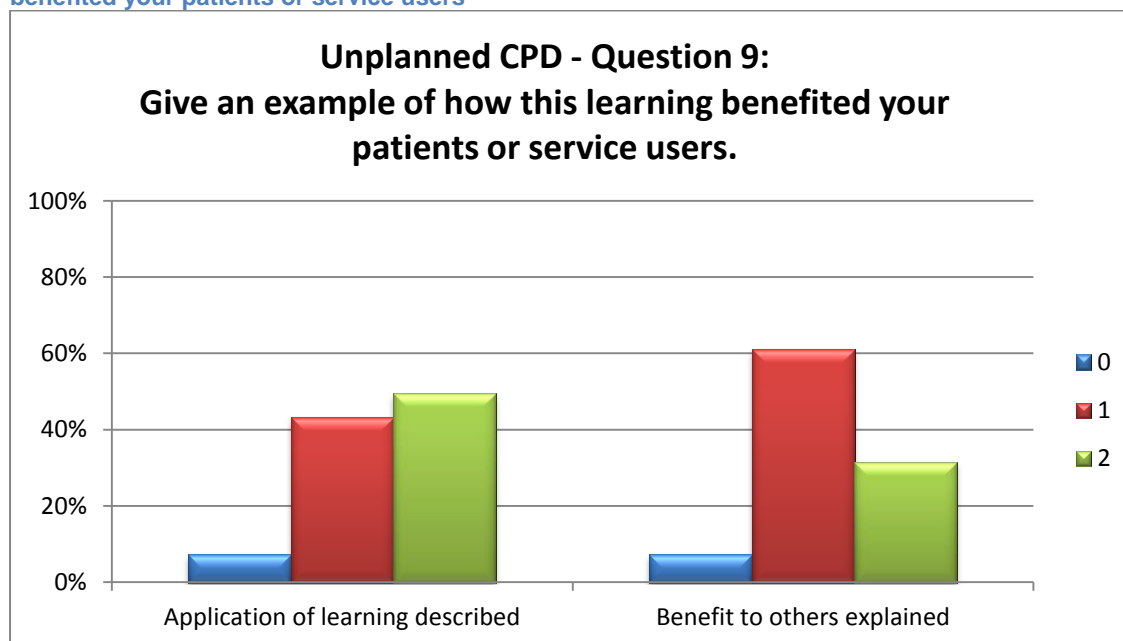
- a) Is there a clear description of the event or activity? (Score: 0 no description; 1 some description; 2 detailed and clear description)
- b) Is there a description of what has been learnt? (Score: 0 no description of learning gained; 1 some description provided; 2 detailed and clear description of learning outcomes)

- (2) Analysis of entries for Question 9: Give an example of how this learning benefited your patients or service users

Most participants demonstrated understanding of the need to apply learning; 92% discussed their learning outcomes and how learning could be applied in practice, and 49% also gave details of actions taken as a result of learning. Again, in regards to benefit to others, 61%

described how their learning could be used to benefit others, however only 32% documented a change in practice and a real example of how others had benefited. The need to demonstrate a change in practice as a result of learning may need further clarification/emphasis in the guidance. Alternatively, participants may need to revisit some entries once learning has been applied and outcomes measured. Results are shown in Figure 41 below.

**Figure 41: Analysis of unplanned learning entries to Question 9: Give an example of how this learning benefited your patients or service users**



- a) Application of learning detailed? (Score: 0 no application of learning (actions taken) described; 1 understanding of how learning could be applied /hypothetical; 2 clear actions taken as a result of learning).
- b) Example of how learning benefits patients/colleagues? (Score: 0 no example given; 1 understanding of benefit/hypothetical example; 2 clear real example of benefit)

### 8.3.3 Unplanned learning entries recommendations

- *Further instructions to explicitly document learning outcomes*
- *Further clarification/emphasis in the guidance around the need to demonstrate a change in practice as a result of learning*
- *The timing of entries may need clarification to support documentation of measured impacts (i.e. entries made once impacts have been realised). Alternatively, multiple entries could be required (i.e. at the time of learning, at implementation of learning and following implementation) in order to assess learning and impacts*

See appendix 8 for two good examples.

## 8.4 Peer Discussion Entries

A peer discussion is defined by GPhC as “a reflective discussion of practice with a colleague or relevant peer(s)”

Reflective Practice is defined by GPhC as “the critical evaluation of practice and learning to find ways to improve outcomes for service users”



#### 8.4.1 Peer discussion entries analysis methodology

Participants were required to address one question for this entry:

- Question 12: Describe how this peer discussion has changed your practice for the benefit of your patients or service users

This question was assessed according to:

- a) the presence of a clear description of the reasons for choosing the peer
- b) a description of how the discussion helped with reflective practice
- c) a description of a change to practice as a result, and d) the benefits to patients/service users (as detailed in guidance provided to participants, see Appendix 4).

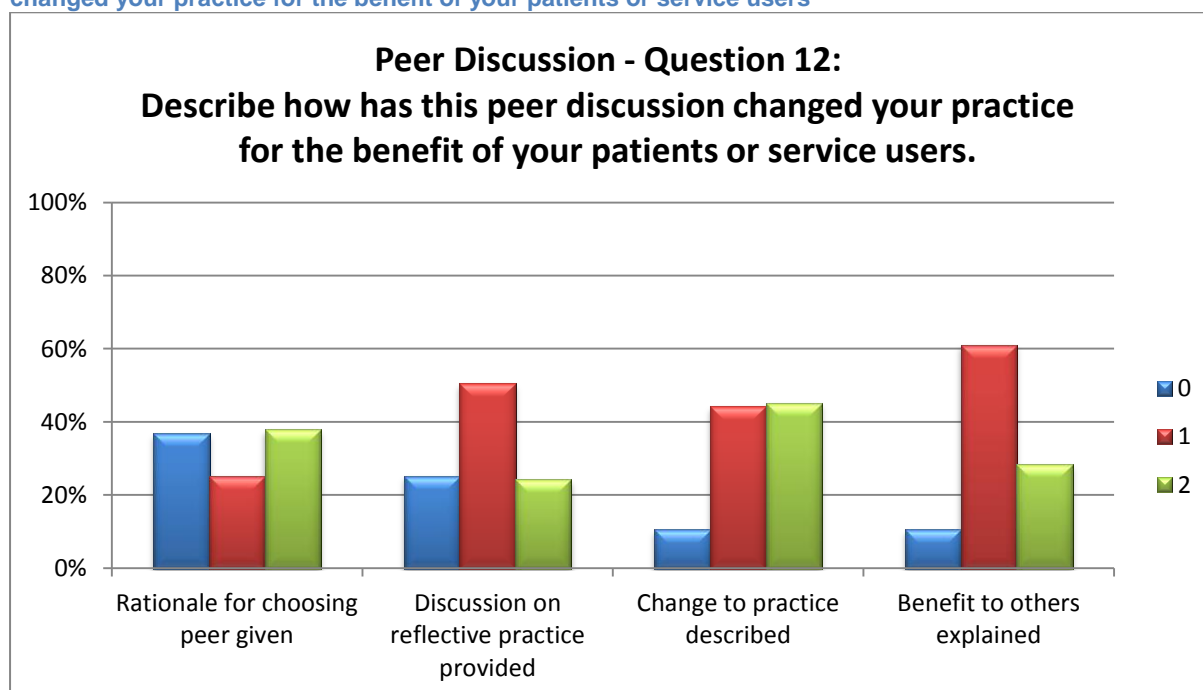
#### 8.4.2 Peer discussion entries analysis findings

##### (1) Analysis of entries for Question 12: Describe how this peer discussion has changed your practice for the benefit of your patients or service users

A large proportion of participants did not give a description of why they chose their peer (37%), and some gave a limited description (25%). Only 38% of participants detailed the reasons for choosing the peer that suggested the choice was based on a development need. This may point to the need for more clarity in detailing the rationale for choosing a particular peer (rewording the question slightly), or more guidance around the selection of appropriate peers. Alternatively participants may have assumed that the rationale for the choice could be inferred from the job title of the peer.

Most participants discussed reflective practice (75%), and 24% gave more detailed responses. However, 24% failed to document how the peer discussion supported reflective practice. As for entries for planned and unplanned CPD, a high proportion of participants gave details of an expected future change to practice as a result of learning gained (44%). Forty-five percent gave a clear example of an implemented change to practice. The benefit to others was also split between those documenting expected benefits (61%) vs those giving clear examples of benefits to others (28%). However, these results may depend on the timing of recording the CPD and whether the activity is conducive to immediate or longer-term benefits. These results are shown in Figure 42 below.

Figure 42: Analysis of peer discussion entries to Question 12: Describe how this peer discussion has changed your practice for the benefit of your patients or service users



- Is there a clear description of the reasons for choosing peer? (Score: 0 no description; 1 basic description; 2 description that suggests that choice of peer was based on development need)
- How did the peer discussion help with reflective practice? (Score: 0 no discussion of how this supported reflective practice; 1 some discussion; 2 clear and detailed discussion)
- Description of change to practice - Specific actions listed? (Score: 0 no application of learning (actions taken) described; 1 understanding of how learning could be applied /hypothetical; 2 clear actions taken as a result of learning)
- Example of how colleagues/patients have benefited? (Score: 0 no example given; 1 understanding of benefit/hypothetical example; 2 clear real example of benefit)

### 8.4.3 Peer discussion entries analysis findings

- *Further clarification and guidance regarding the choice of peer to ensure participants are choosing peers based on training needs*
- *Further instructions for participants to explain the relevance of the peer to their training needs*
- *Further instructions for participants to illustrate reflective practice in their entries*
- *The timing of entries may need clarification if measured impacts are to be documented (i.e. entries made once impacts have been realised). Alternatively, multiple entries could be required (i.e. at the time of learning, at implementation of learning and following implementation) in order to assess learning and impacts*

See Appendix 9 for two good examples.

## 8.5 Case Study Entries

A case study is defined by GPhC as “an example of a change to practice related to Standard 3 of the new draft standards for pharmacy professionals; ‘Communicate effectively’”

### 8.5.1 Case study entries analysis methodology

Participants were required to address one question for this entry:

- Question 13: Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals, that has benefited your patients or service users.

As detailed in the guidance to participants (see Appendix 4), this question was assessed according to:

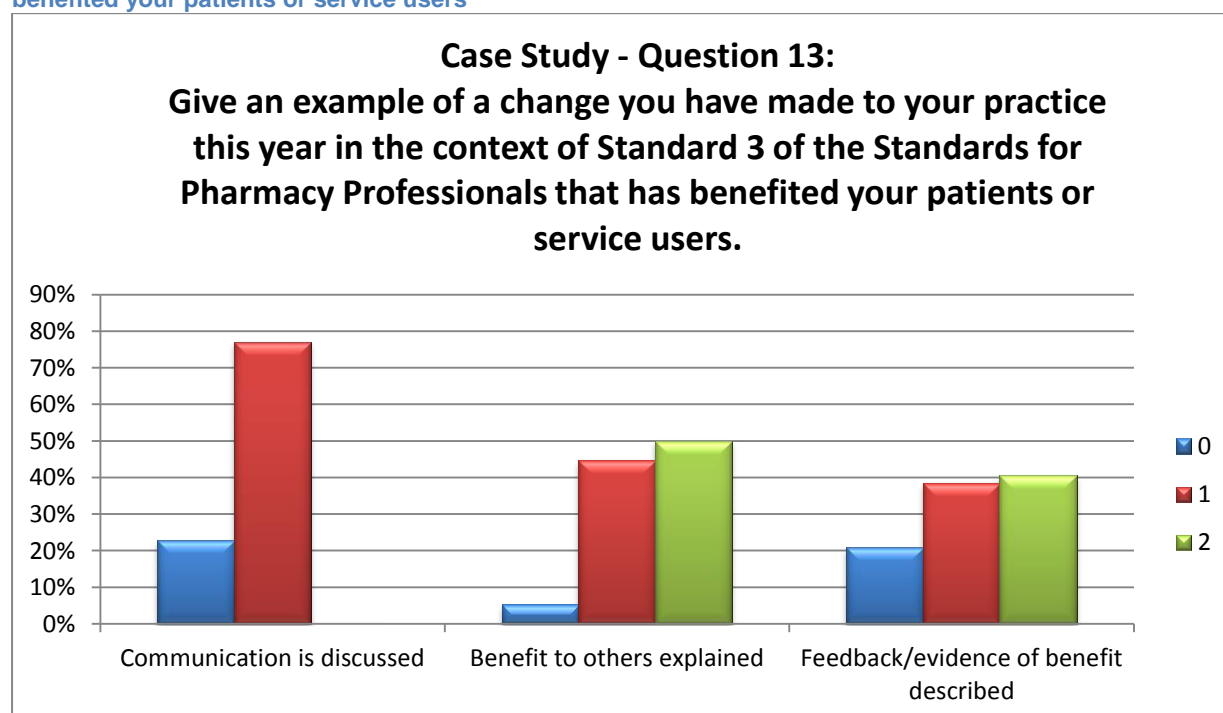
- a) the presence of a clear description of a change in practice related to effective communication
- b) an example of how the learning has benefited patients or colleagues
- c) evidence of beneficial impact through feedback or other evidence

### 8.5.2 Case study entries analysis findings

- (1) Analysis of entries for Question 13: Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals, that has benefited your patients or service users.

The vast majority of participants discussed learning around the topic of 'effective communication' (77%) in their entry, however 23% did not explicitly discuss communication. Half described clear benefit to patients/colleagues, as illustrated with an example. The majority of other responses demonstrated an understanding of how learning could benefit others in the future (45%). These results are shown in Figure 43 below.

**Figure 43: Analysis of case study entries to Question 13: Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals, that has benefited your patients or service users**



- a) Is a change in practice related to 'Communicate effectively' described? (Score: 0 no evidence of learning around effective communication; 1 Effective communication is discussed)
- b) Example of how learning has benefited patients/colleagues (Score: 0 no example given; 1 understanding of benefit/hypothetical example; 2 clear real example of benefit)
- c) Feedback/evidence relating to beneficial impact of change (Score: 0 no clear feedback/benefit described; 1 some feedback/benefit described; 2 clear and specific feedback/evidence of benefit)





As illustrated in the quotes below, most participants provided evidence/feedback detailing some impact of the learning (80%); and some gave more specific details (41% of respondents).

*“This new approach to how we communicate as a department to the public has already been seen to improve patient participation in our campaigns. From speaking to customers during the day and afterwards it was clear to me that this method was highly effective not only in the health promotion but also in their views on us as a pharmacy. It also directly benefited some customers with referrals to the GP about their issues which otherwise may have been left for a longer period of time, resulting in more discomfort for the patient or a worsening of condition showing that by changing the ways in which we communicate effectively can have a positive result.”*

*“So far the feedback I have received about my communication has been positive. I have had recent feedback from a colleague who said that I handled what could have been a very difficult conversation amazingly well and left the person in a positive frame of mind and I have also had feedback from a training session that I ran on Wellbeing and Stress from a number of colleagues who said they really enjoyed the session and felt really motivated and inspired from it..”*

### 8.5.3 Case study entries recommendations

- Further instructions to explicitly discuss communication
- Further instructions to discuss reflective practice around their communication
- The timing of entries may need clarification if measured impacts are to be documented (i.e. entries made once impacts have been realised). Alternatively, multiple entries could be required (i.e. at the time of learning, at implementation of learning and following implementation) in order to assess learning and impacts

See appendix 10 for two good examples.

## 8.6 Analysis by key demographic characteristics

All scored entries were further analysed by demographic characteristics: gender (Female/Male); role (Pharmacist/Pharmacy Technician); Full time/Part time workers; Country (England/Scotland/Wales); ethnic background (British/Indian/Other); and employment setting. We sought to investigate any differences in the proportion of high scores (scores of 2) between different population groups. An explanation of the statistical methods and analysis can be found in Appendix 3 and the method used was as published by the Association of Public Health Observatories <sup>3</sup>. The numbers of participants sampled from each demographic group is detailed in Table 20 below.

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<sup>3</sup> Analytical tools for Public Health, Association of Public Health Observatories, February 2014 [www.apho.org.uk/resource/view.aspx?RID=48617](http://www.apho.org.uk/resource/view.aspx?RID=48617)

**Table 20: Detailing numbers of participants by demographic characteristic**

	Planned CPD			Unplanned CPD			Peer discussion			Case study		
Demographic characteristic	Participants (entries)	actual %	ideal %	Participants (entries)	actual %	ideal %	Participants (entries)	actual %	ideal %	Participants (entries)	actual %	ideal %
Gender												
Female	68 (73)	69%	69%	56 (63)	67%	69%	69 (72)	75%	69%	61 (62)	64%	69%
Male	31 (35)	31%	31%	28 (32)	33%	31%	23 (23)	25%	31%	34 (34)	36%	31%
Role												
Pharmacist	74 (83)	75%	78%	62 (71)	74%	78%	69 (70)	75%	78%	69 (69)	73%	78%
Pharmacy Technician	25 (25)	25%	22%	22 (24)	26%	22%	23 (25)	25%	22%	26 (27)	27%	22%
Work time												
Part time	29 (37)	29%	27%	27 (33)	32%	27%	28 (28)	30%	27%	26 (26)]	27%	27%
Full time	70 (71)	71%	73%	57 (62)	68%	73%	64 (67)	70%	73%	69 (70)	73%	73%
Country												
England	75 (82)	76%	79%	55 (62)	65%	79%	69 (70)	75%	79%	68 (68)	72%	79%
Scotland	13 (13)	13%	16%	18 (18)	21%	16%	14 (16)	15%	16%	15 (16)	16%	16%
Wales	11 (13)	11%	5%	11 (15)	13%	5%	9 (9)	10%	5%	12 (12)	13%	5%
Ethnic group												
British	72 (80)	73%	72%	63 (70)	75%	72%	72 (74)	78%	72%	72 (73)	76%	72%
Indian	10 (11)	10%	10%	8 (11)	10%	10%	8 (8)	9%	10%	7 (7)	7%	10%
Other	17 (17)	17%	18%	13 (14)	15%	18%	12 (13)	13%	18%	16 (16)	17%	18%
Employment setting												
academic / educational	9 (13)	9%	8%	10 (11)	12%	8%	13 (14)	14%	8%	11 (12)	12%	8%
advisory / regulatory	4 (4)	4%	5%	4 (6)	5%	5%	4 (4)	4%	5%	3 (3)	3%	5%
hospice care	0 (0)	0%	0%	2 (2)	2%	0%	0 (0)	0%	0%	2 (2)	2%	0%
hospital	24 (28)	24%	25%	16 (19)	19%	25%	26 (26)	28%	25%	21 (21)	22%	25%
hospital / community locum / portfolio worker	0 (0)	0%	0%	1 (2)	1%	0%	1 (1)	1%	0%	0 (0)	0%	0%
independent community pharmacy	13 (13)	13%	14%	8 (8)	10%	14%	8 (8)	9%	14%	13 (13)	14%	14%
industry / science	3 (3)	3%	2%	2 (2)	2%	2%	1 (2)	1%	2%	5 (5)	5%	2%
military	2 (3)	2%	2%	3 (3)	4%	2%	1 (1)	1%	2%	2 (2)	2%	2%
multiple community pharmacy	30 (30)	30%	30%	21 (24)	25%	30%	24 (25)	26%	30%	28 (28)	29%	30%
primary care / GP practice	12 (12)	12%	13%	15 (16)	18%	13%	12 (12)	13%	13%	10 (10)	11%	13%
secure (prison / mental health)	2 (2)	2%	1%	2 (2)	2%	1%	2 (2)	2%	1%	0 (0)	0%	1%

Participant's column shows the number of participants in the sample of each characteristic. Numbers in brackets refer to the actual numbers of entries scored; this figure is occasionally higher than the number of participants where multiple entries by individuals have been analysed. Percentages show the actual proportions of each characteristic in the sample compared to the ideal percentages as determined by the proportions in the total population of participants.

**On the whole, differences between groups were not found to be statistically significant across all CFtP activities.** However, this may be related to relatively small numbers in the sample sub-groups, and where trends were seen it would be worth monitoring future entries for differences between groups.

### 8.6.1 Analysis by sex

Figures 44 to 47 below show gender differences relating to each of the entry types. These show that there were no statistically significant differences between women and men in achieving a high score for questions relating to planned CPD, unplanned CPD, Peer Discussion or Case Studies.

They suggest that the variations between female and male respondents may be due to chance, as the overlapping confidence intervals (error bars) demonstrate a lack of statistical significance in the estimates. For example 77% of women are estimated to provide a good answer in regards to learning objectives, compared to 60% of men. However, the true population value for women could be as low as 68%, and the true population value for men could be as high as 74%. Therefore we cannot conclude that women did better on this question compared to men from these results. However, larger samples would give more precise estimates and may show up differences; further analysis at a future date may be worth considering.

**Figure 44: Analysis of planned CPD entries by gender**

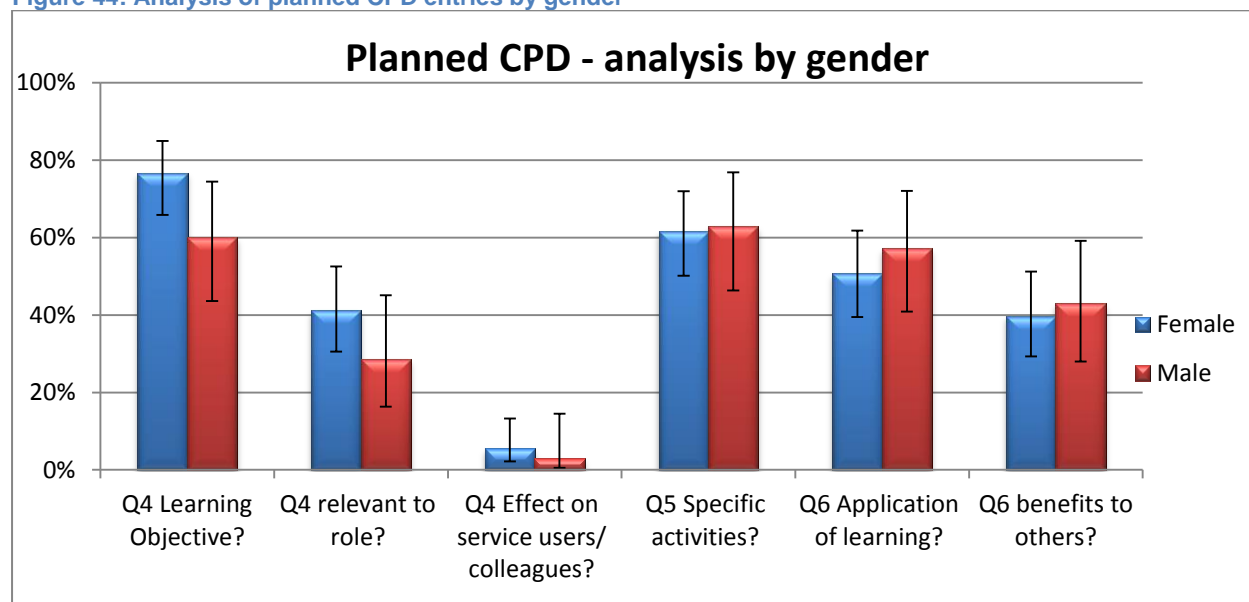


Figure 45: Analysis of unplanned CPD entries by gender

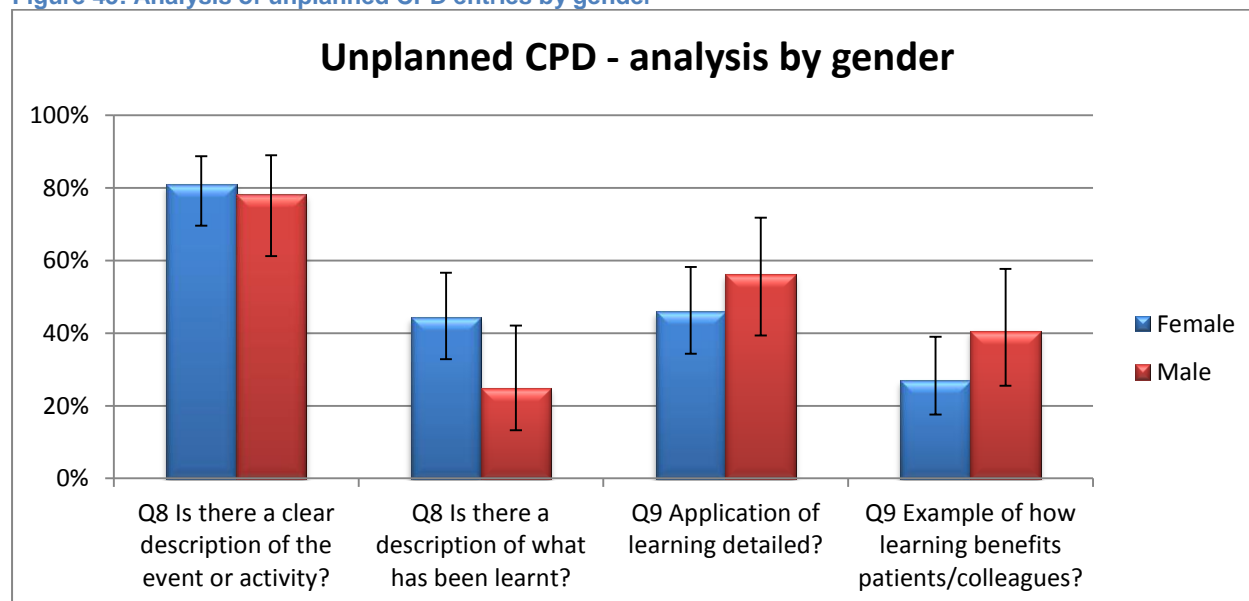


Figure 46: Analysis of peer discussion CPD entries by gender

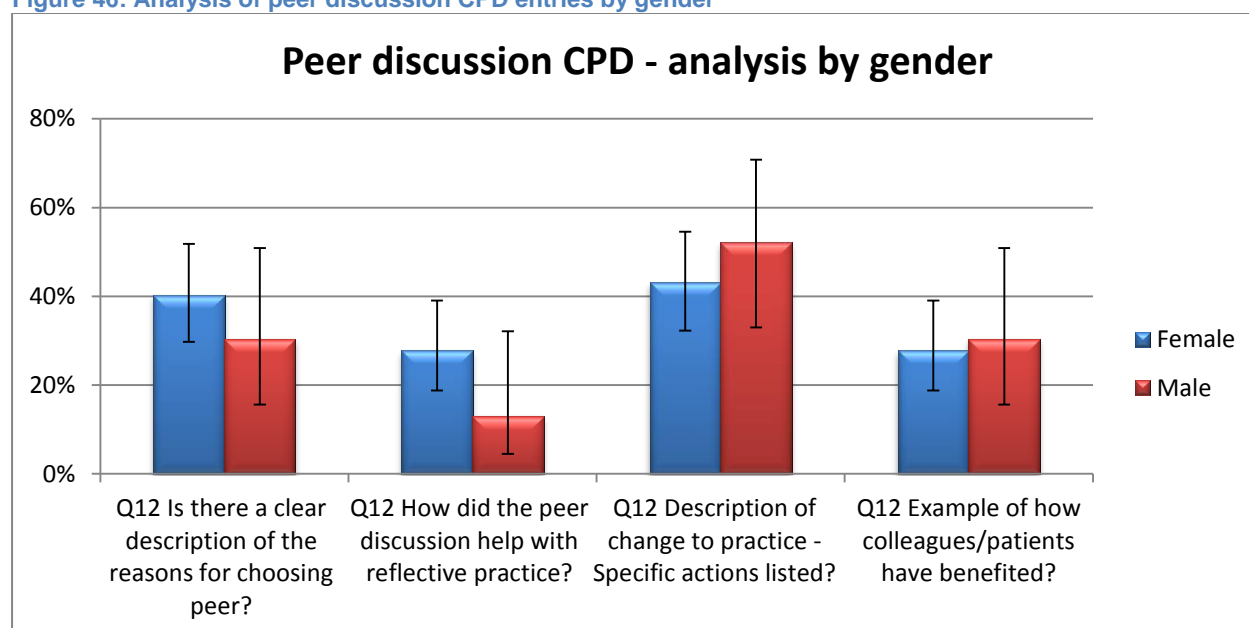
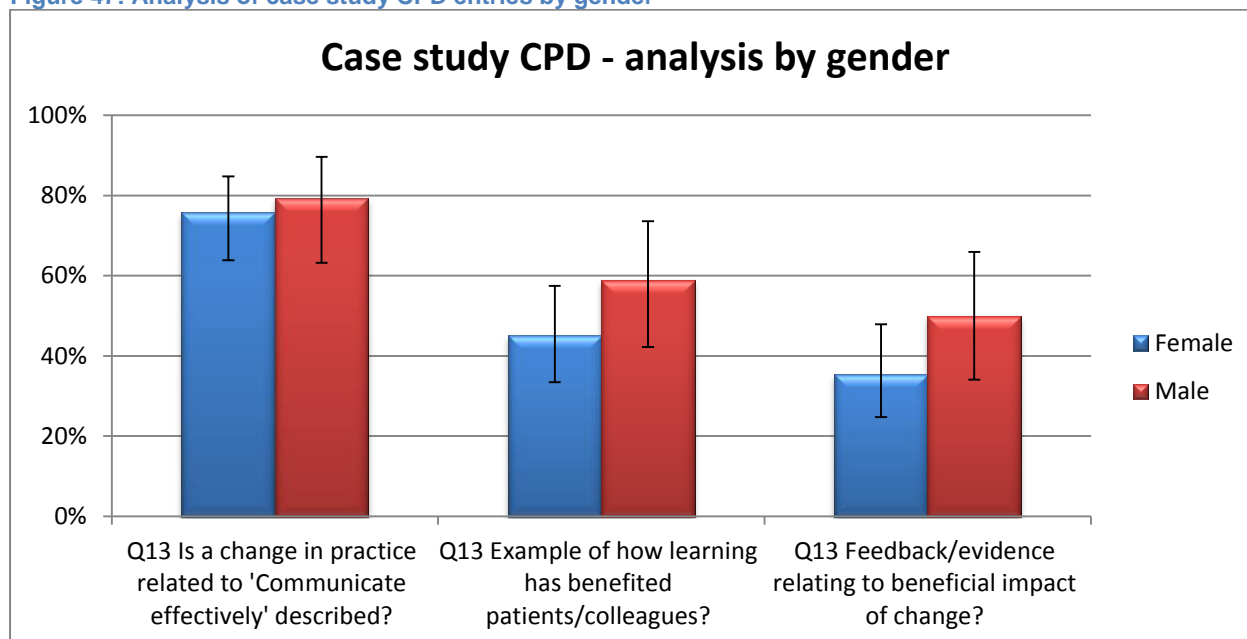


Figure 47: Analysis of case study CPD entries by gender



### 8.6.2 Analysis by Role

As shown in Figures 48 to 51 below, no statistically significant differences were observed between Pharmacists and Pharmacy Technicians in the proportions achieving a high score for their entry. Overall, there may be a slight trend for Pharmacists to gain higher scores compared Pharmacy Technicians, for example in relation to application of learning, although these differences may also be due to chance. Further analysis with larger samples sizes may clarify possible trends in the data.

Figure 48: Analysis of planned CPD entries by role

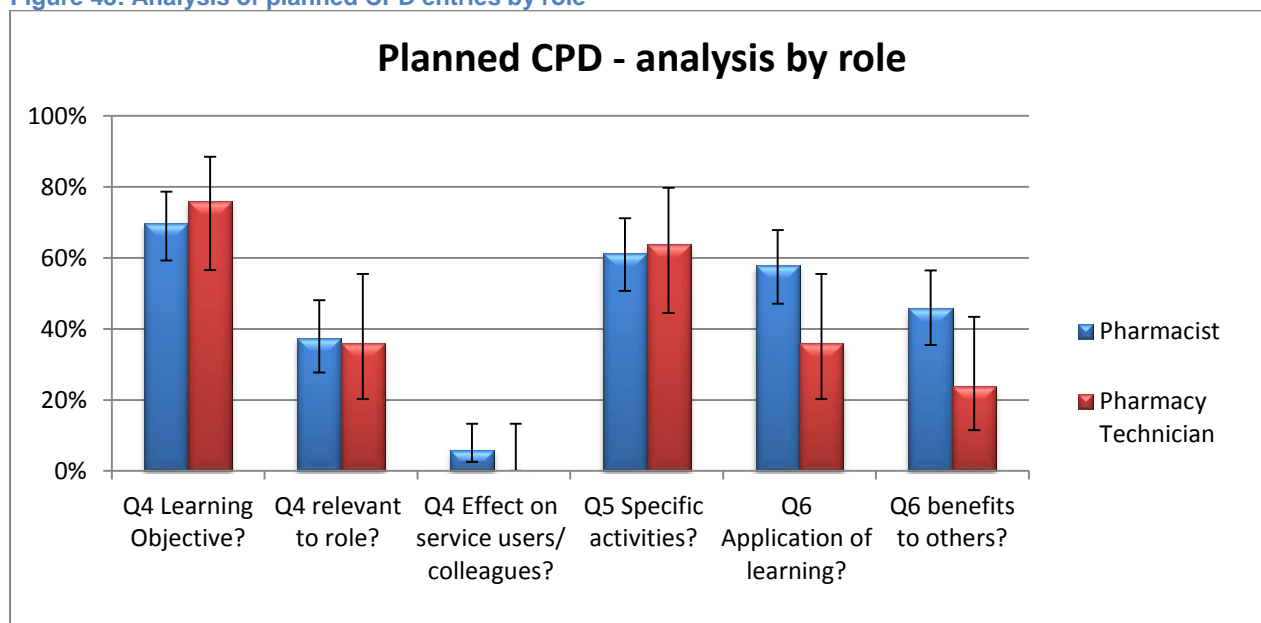


Figure 49: Analysis of planned CPD entries by role

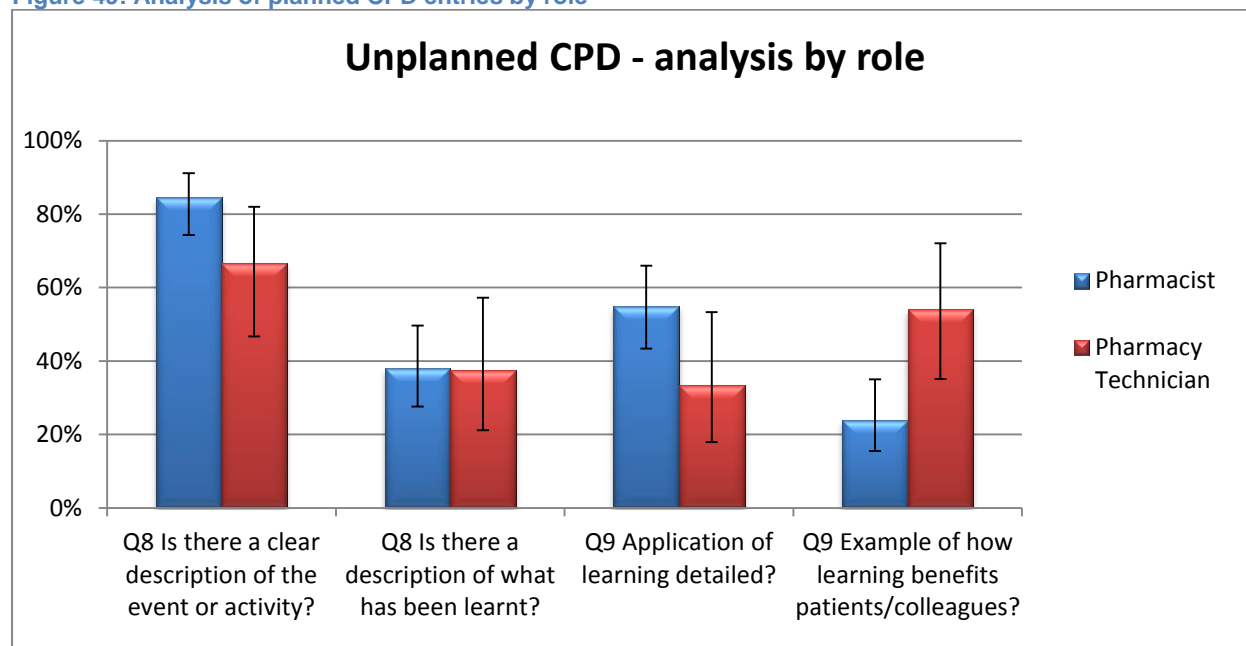


Figure 50: Analysis of peer discussion CPD entries by role

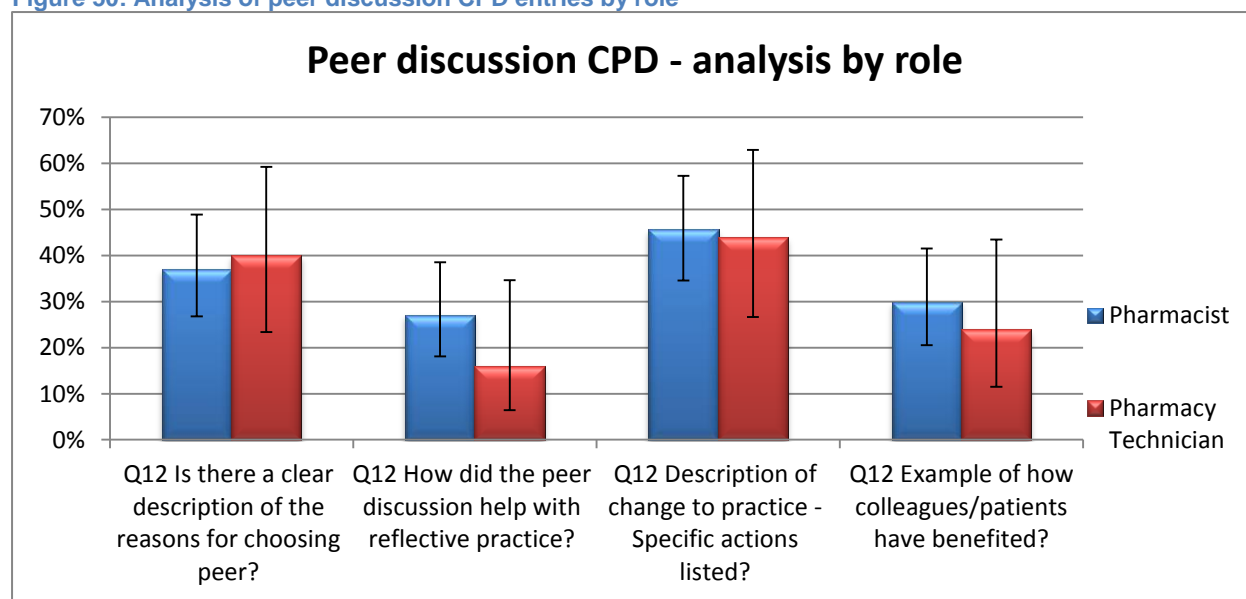
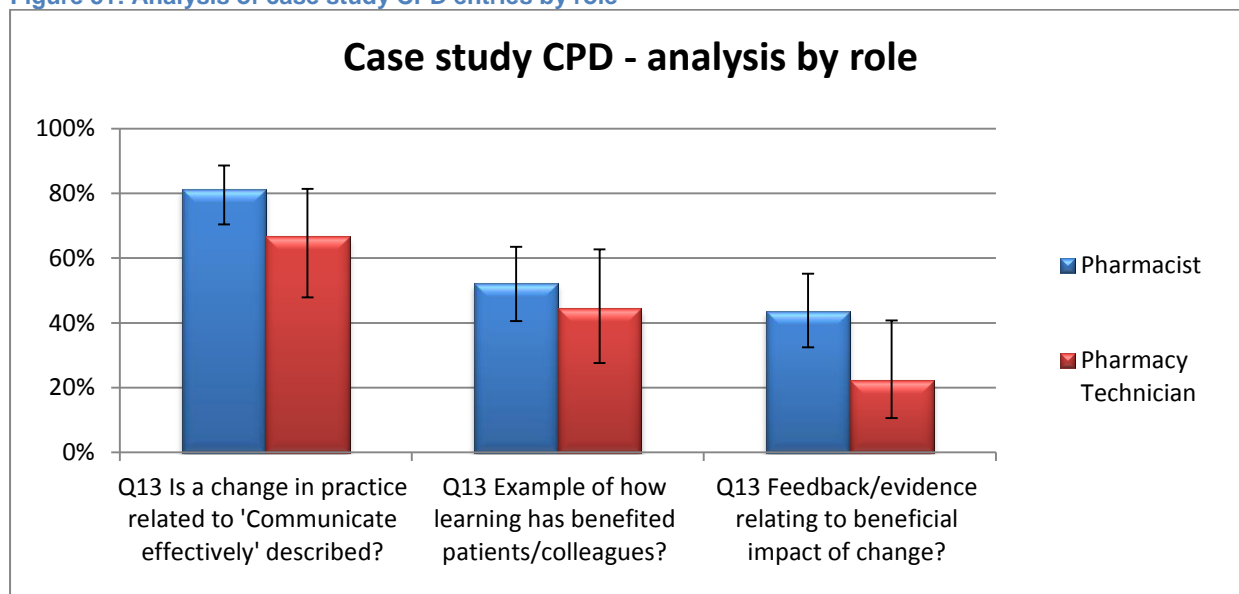


Figure 51: Analysis of case study CPD entries by role



### 8.6.3 Analysis by Full Time / Part Time

The proportions of full-time verses part-time staff achieving high scores were very similar. No statistically significant differences were observed between the two population groups, as shown in Figures 52 to 55 below. This suggests that part time staff are as able as full time staff to provide entries of a good standard, including, for example, reflecting on learning and demonstrating benefits to patients/colleagues.

Figure 52: Analysis of planned CPD entries by full time vs part time

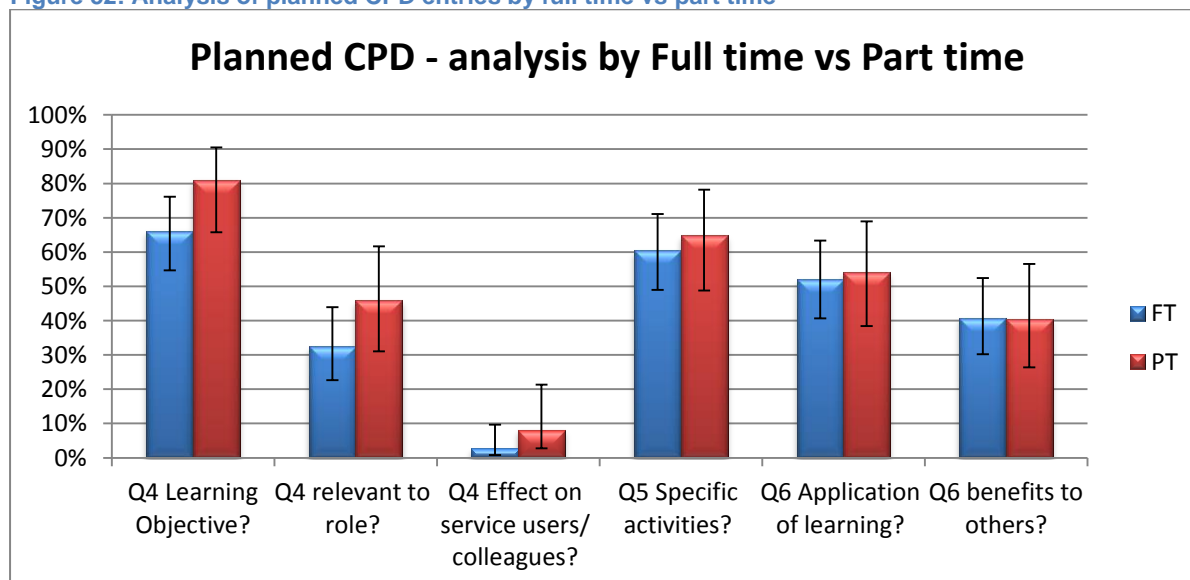


Figure 53: Analysis of unplanned CPD entries by full time vs part time

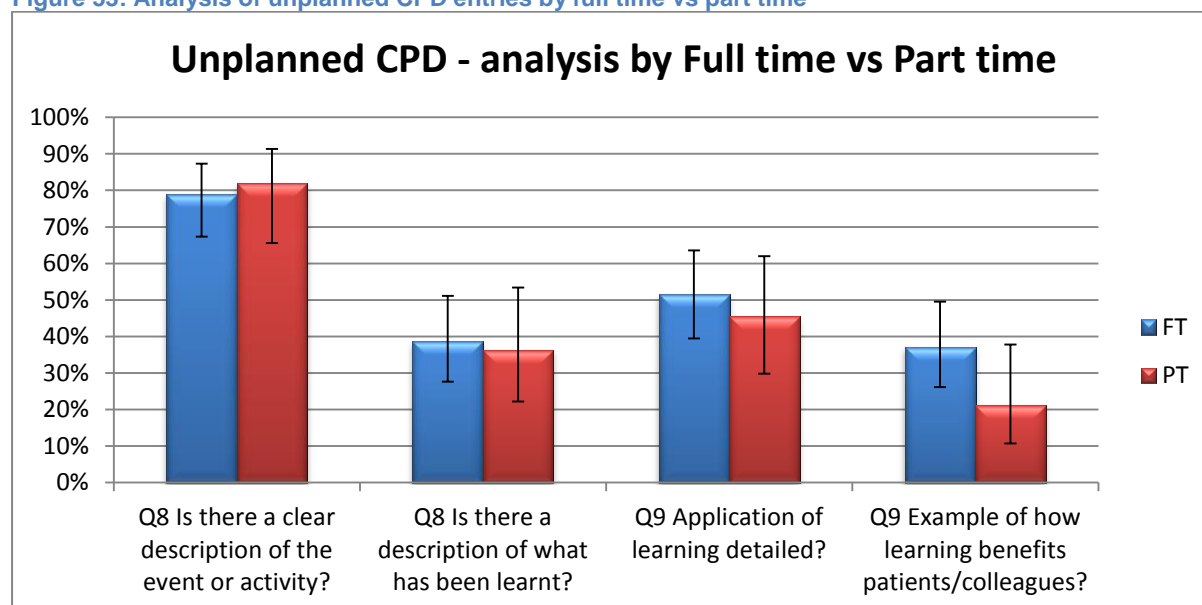


Figure 54: Analysis of peer discussion CPD entries by full time vs part time

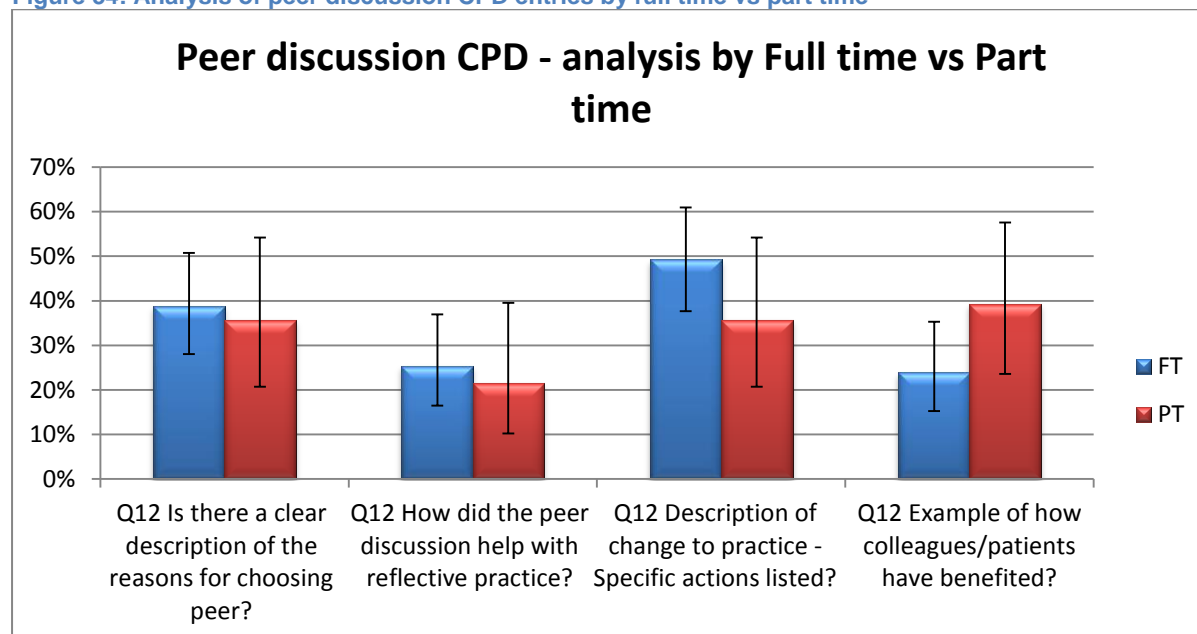
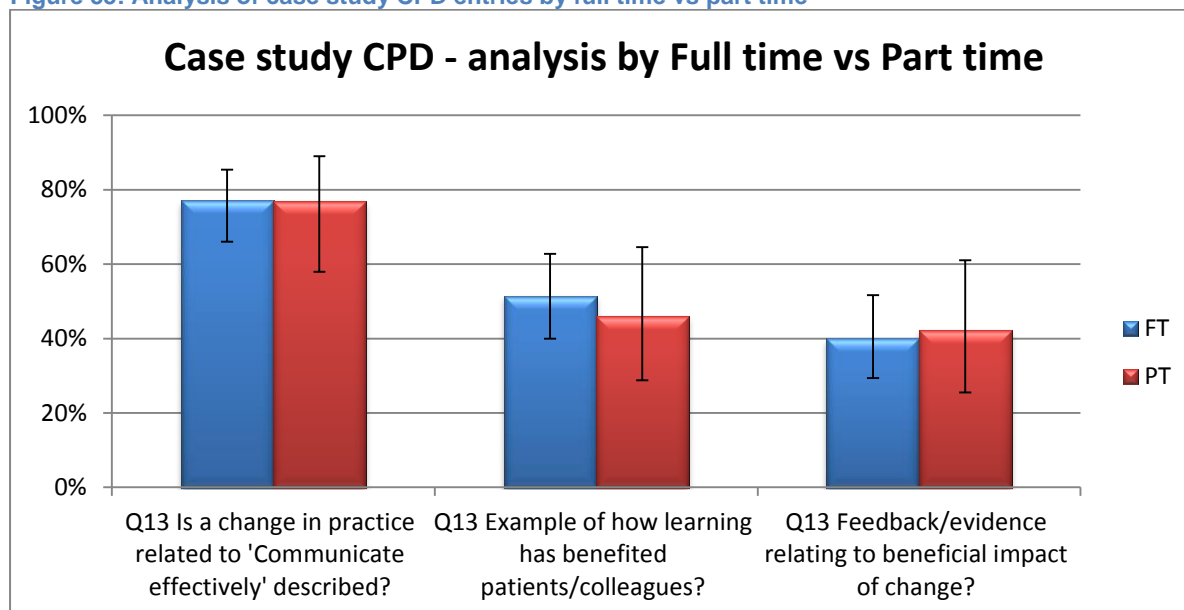




Figure 55: Analysis of case study CPD entries by full time vs part time



#### 8.6.4 Analysis by Country

Data entries were also analysed by the country in which the respondent works, as shown in Figures 56 to 59 below. Less precise estimates (wider confidence intervals) were obtained for Scotland and Wales compared to England due to fewer entries from these countries. Overall, there may be a slight trend for higher scores for Scottish and Welsh entries compared to those from participants in England, although this may also be due to random variation. One significant result was found between participants in England compared to Wales for the Peer Discussion. Here the question around documenting a change in practice, was answered more comprehensively (higher score achieved) by participants from Wales compared to England. However, the difference was small and may not persist with a larger sample size. [This evidence suggests that there are no particular structural difficulties by country of work that could impede good CFtP entries.](#)

Figure 56: Analysis of planned CPD entries by country

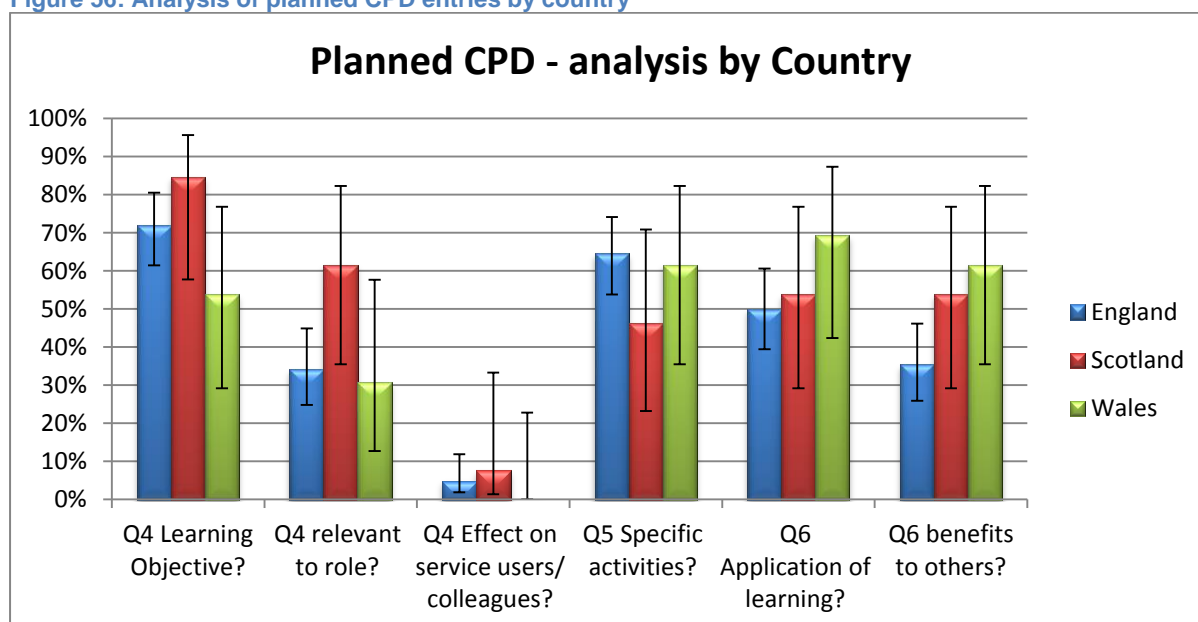


Figure 57: Analysis of unplanned CPD entries by country

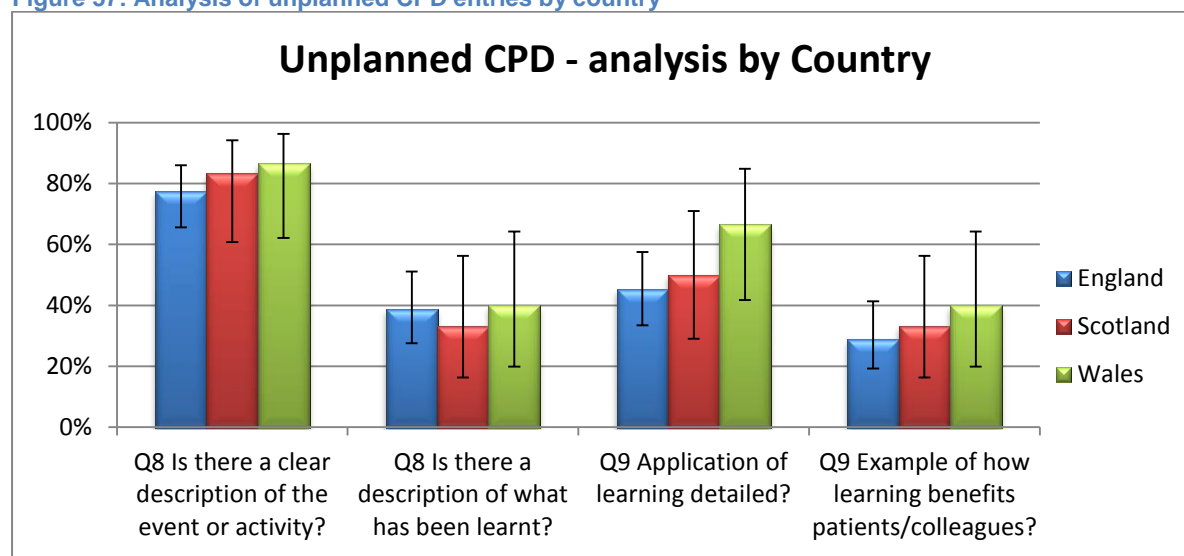


Figure 58: Analysis of peer discussion CPD entries by country

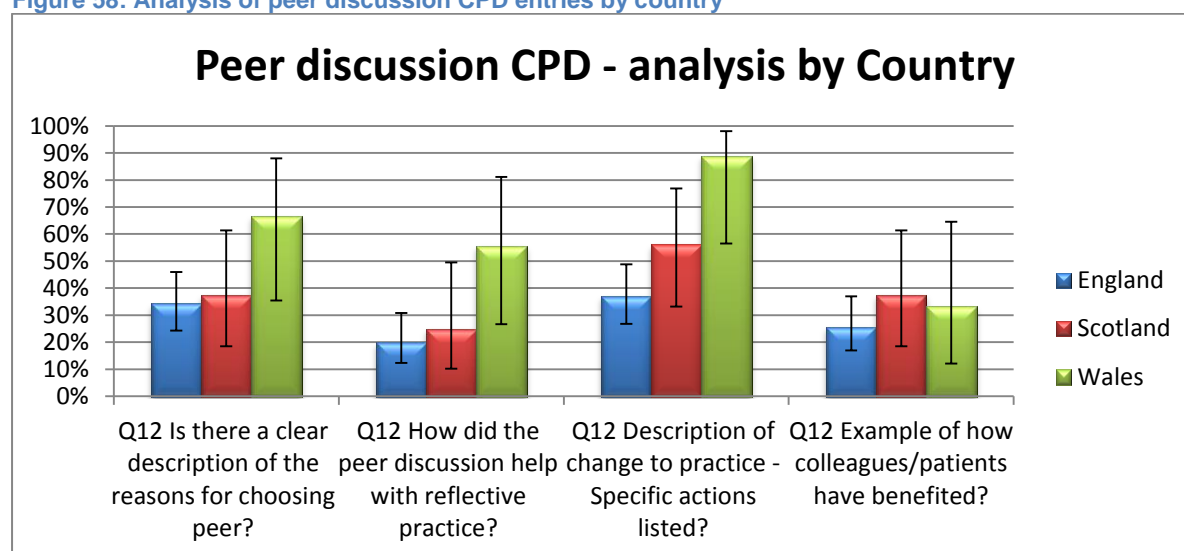
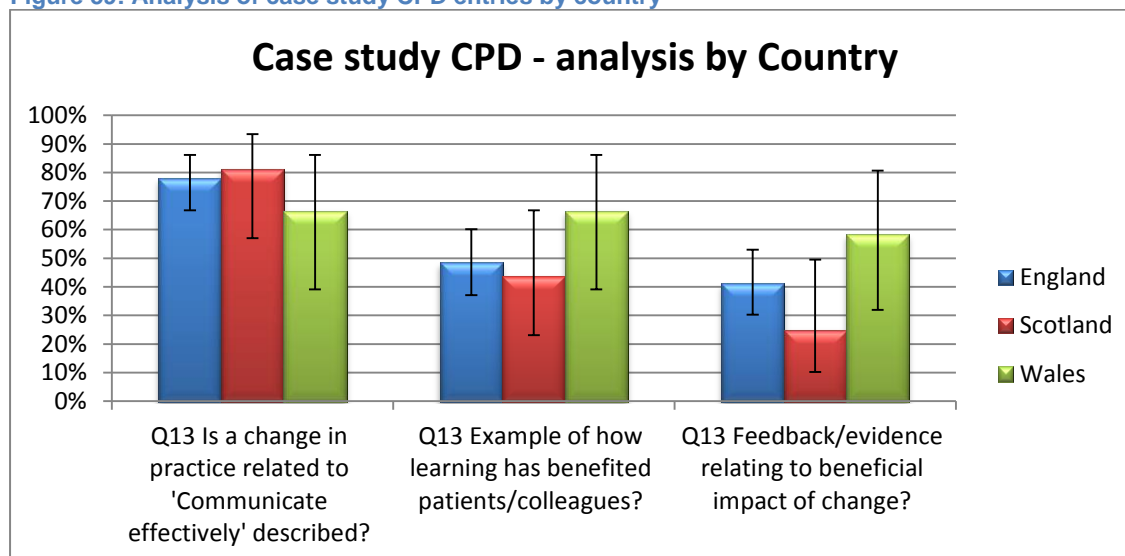


Figure 59: Analysis of case study CPD entries by country



### 8.6.5 Analysis by ethnic group

On the whole, no significant differences were observed in the analysis by ethnic background, as shown in Figures 60 to 63 below. Wider variation in the estimates for 'Indian' and 'Other' groups are obtained due to smaller numbers of respondents in these categories. One significant difference between participants identifying as 'British' compared to 'Other', was observed for the Planned CPD question on learning objectives. Here British participants gave more comprehensive answers compared to those identifying as 'Other'. However, the difference was small and may not persist with a larger sample size. Overall, these results suggest that any difference in English language skills or other cultural influences do not appear to affect the ability of respondents to make good CPD entries.

Figure 60: Analysis of planned CPD entries by ethnic group

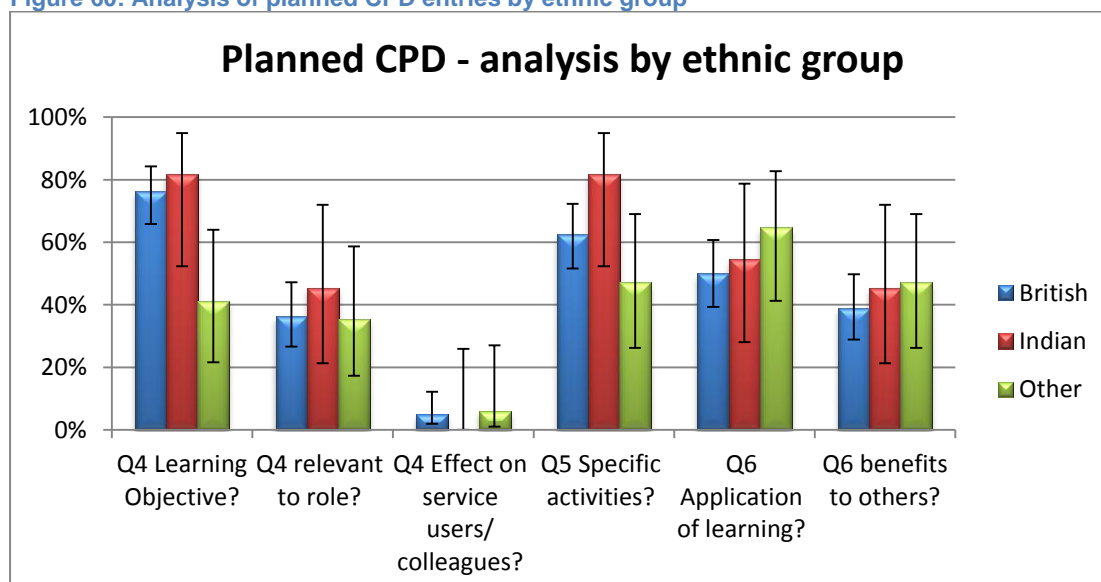


Figure 61: Analysis of unplanned CPD entries by ethnic group

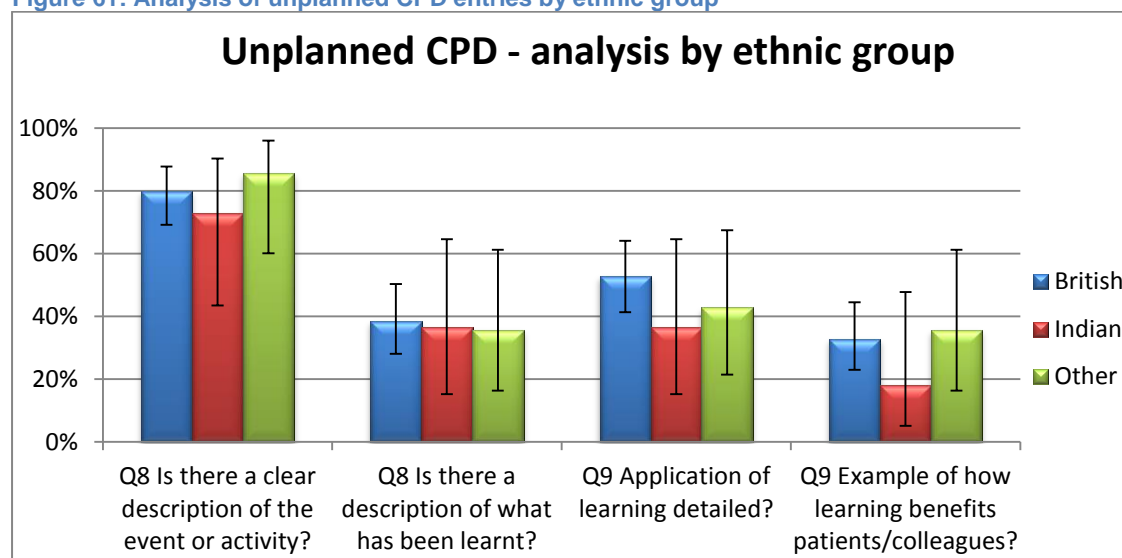


Figure 62: Analysis of peer discussion CPD entries by ethnic group

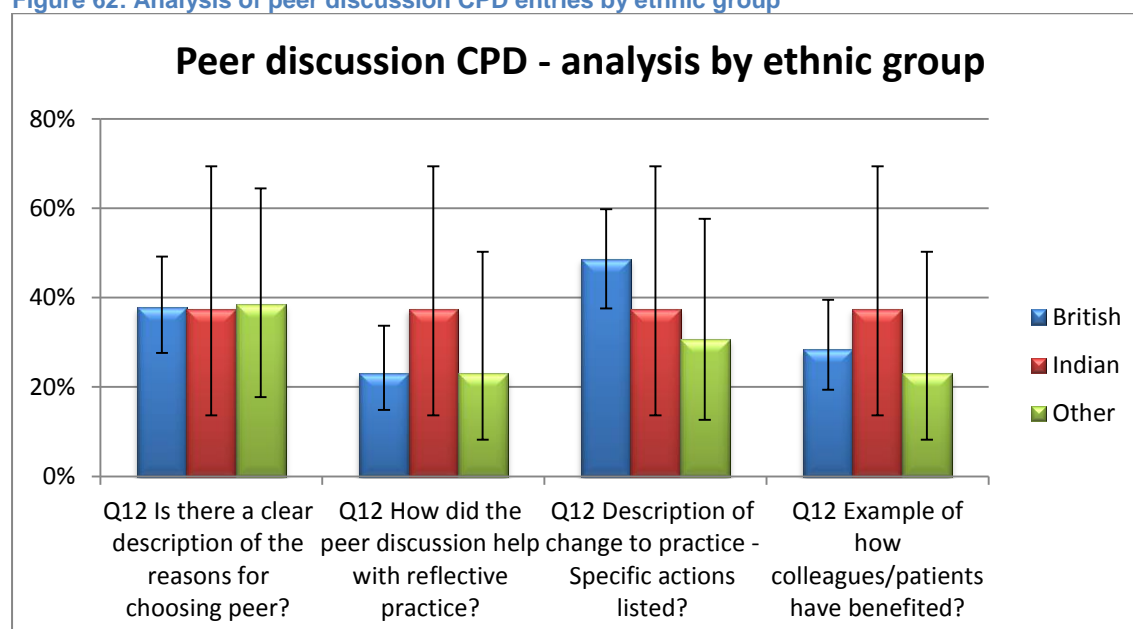
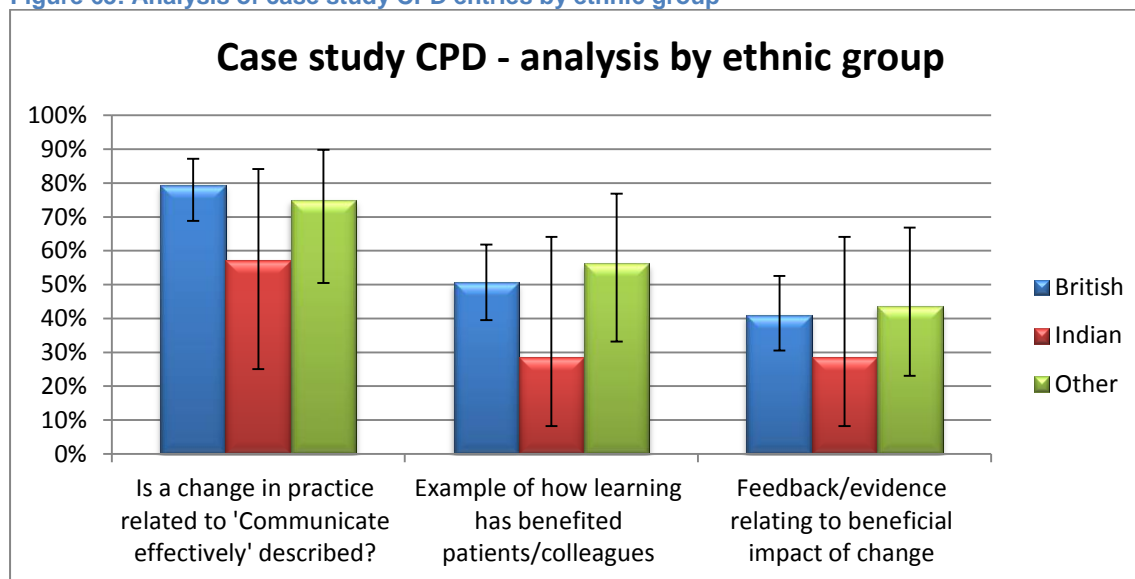


Figure 63: Analysis of case study CPD entries by ethnic group



### 8.6.6 Analysis by Setting

Analysis by employment setting was more challenging due to small numbers in each sub-category. Overall, there were no statistically significant differences in the proportion of high scoring entries by workplace setting. This result suggests that the ability of respondents to make good CPD entries was not related to their workplace setting. However, further analysis on future entries is advisable to confirm this result as the estimates are imprecise (large confidence intervals) (data not shown).

In addition to analysis of the proportion of high scores (score of 2) in each demographic category, the same analysis was performed for the proportion of adequate/good scores (scores of 1 or 2). Very similar results were obtained, with no statistically significant differences observed for any demographic group (data not shown).

## 8.7 Findings against Desired Outcomes

The following summary addresses each point in the evaluation logic model for which analysis of database entries can provide evidence.

### 8.7.1 Outcome 1: The proposed approach is simple to use

- Overall participants recorded relevant information for each CPD type.
- Areas requiring further clarification include instructions to:
  - document relevance of the activity to their role
  - give descriptions of what has been learnt
  - explaining the rationale for choice of peer
- 77% of participants found suitable case studies in which they could discuss learning around 'effective communication'. Communication was not explicitly discussed in the remaining 23% of case studies completed.

### 8.7.2 Outcome 2: The proposed approach encourages participation

Participants were able to reflect on learning needs and could identify activities to meet those needs. However, measuring the impact of learning and any future development was a hypothetical concept for many.

If future development needs are to be identified and documented by participants, this may require an additional question specifically addressing this point to be added to the database system. Alternatively, the GPhC may wish to make clear in their guidance that the CFtP is not intended to act as a lifelong learning portfolio.

### 8.7.3 Outcome 3: The proposed approach encourages reflective learning, demonstrates an impact on patients or service users and where appropriate, is reflective of the GPhC Standard 3 - Communicate Effectively

- Overall the majority of participants reflected on their learning needs and explained to some degree the relevance to their role. However, around a third of participants completing planned CPD entries failed to document the relevance, and 37% of participants completing peer discussion failed to document why the peer was chosen.
- This points to the need for clarification in the level of detail required for these entries, or for more specific instructions around what is expected when choosing appropriate CPD activities
- The vast majority of participants were able to reflect on their learning and described the application of this learning to their practice. For many, the benefits to others (patients/colleagues) were expressed in future hypothetical terms.
- If real measurable benefits are desirable, it may be necessary for participants to review entries at later dates in order to document this impact, and this requirement will need to be clearly explained.
- The standard 'Effective Communication' was specifically addressed by the case studies. Here 77% chose a case study to demonstrate reflection on this standard. However all other pharmacy standards were addressed to varying degrees through the different CPD activities.
- All participants drew on real events and evidence in their examples of learning and development.
- Many participants described actual impacts of their learning on patients or service users. However, the majority described hypothetical future impacts, rather than a measured change. This may be a reflection of the timing of CPD entries and the wording of the questions; i.e. 'what are you planning to learn?' If measured impacts are required, greater clarity maybe required detailing the timing of CPD entries in relation to the activity, alternatively CPD entries may need to be revisited once the impacts have been realised.

Most participants demonstrated an understanding that learning should lead to a change in practice and a subsequent benefit to patients/colleagues.

### 8.7.4 Outcome 4: The proposed approach incurs negligible additional time and other costs

Although addressed elsewhere in the report, this question was not asked within the pilot database and so is not addressed here.

### **8.7.5 Outcome 5: The proposed approach is fair and equitable**

- Overall, the proportions of good entries observed by gender; role; work time (full/part time); country; ethnic group (British/Indian/Other), or employment setting, were very similar. However, future analysis with larger samples sizes may clarify possible trends in the data, and allow statistically meaningful analyses where there are relatively few individuals with particular characteristics. Disability data was not analysed due to small numbers. As such, future analysis is recommended to ensure there are no specific challenges for people with disabilities.

### **8.7.6 Outcome 6: Participants understand the rationale for and requirements of the proposed approach**

- An understanding of the purpose of CFtP and the different CPD activities was illustrated by the level of engagement demonstrated by participants. The vast majority of those participating in the pilot gave thorough and considered answers to the questions posed.
- Overall a good understanding of expectations was evident. However, clarification around choosing relevant learning activities and documenting real impacts could improve the process.

The terminology appeared to be understood in general. Clarification around documenting the rationale for choosing the activity/peer/case study, may improve the process. Clarification around documenting real impacts and patient benefits, may also improve the process.

### **8.7.7 Outcome 7: The proposed approach is seen by stakeholders as providing assurance of fitness to practice**

Although addressed elsewhere in the report, this question was not asked within the pilot database and so is not addressed here.

### **8.7.8 Outcome 8: Peer discussions are robust and appropriate**

Further clarification may be needed to ensure participants document the rationale for choosing their peer. Additionally, the goal of 'reflective practice' through peer discussion may need further emphasis in the instructions to participants.

### **8.7.9 Outcome 9 Each element of CFtP meets its' objectives**

- For planned learning, overall participant entries demonstrated clear learning objectives with specific activities and application of learning well documented. The relevance of the activity to the role was less well documented, and the effect/benefits to others were hypothetical in many instances.

Unplanned learning activities were generally well described. Application of learning and benefits to others was hypothetical in many cases.

- Overall peer discussions either demonstrated or discussed reflective practice. A change to practice was generally documented, although benefits to patients/colleagues were often hypothetical.

The majority (77%) of case studies documented a change related to 'communicate effectively'. Overall, benefits to others and positive feedback were discussed in the case studies.

#### **8.7.10 Outcome 10 Any unexpected consequences are identified**

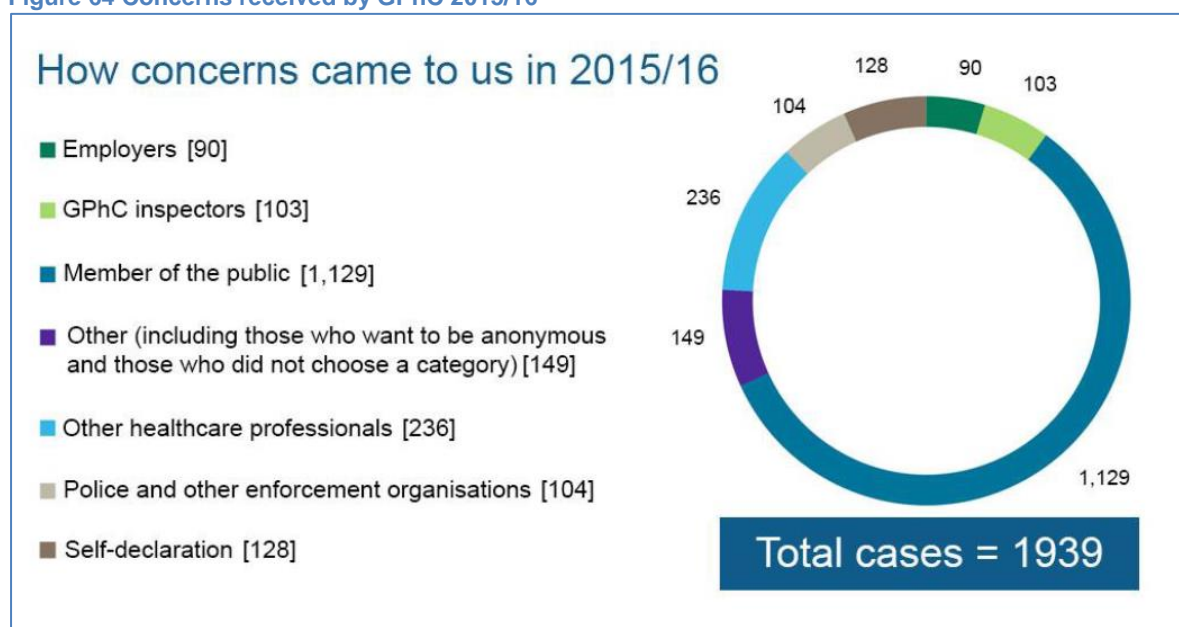
Although addressed elsewhere in the report, this question was not asked within the pilot database and so is not addressed here.



## 9 Patient, Public and Service User Focus Group

Gaining the views and understanding of service user representatives is important. Figure 65 below, from the GPhC 2015/16 Annual Fitness to Practise Report, shows that 58% of all concerns about pharmacy professionals and pharmacy services were raised by members of the public.

Figure 64 Concerns received by GPhC 2015/16



Source: GPhC Annual Fitness to Practise Report 2015/16

### 9.1 Methodology

The GPhC regularly involves patients, carers and users of pharmacy services in their work and have a patient and public advisory panel consisting of about 200 people nationwide. Nine members of the panel attended a focus group in November 2016

The aim of the focus group was to ascertain whether these members of the public consider the proposed CFtP framework to be robust and proportionate and to give appropriate and sufficient assurance to patients and the wider public about the fitness to practise of individual pharmacists and pharmacy technicians, and the pharmacy profession as a whole.

The CFtP Framework was introduced to the group and how it differs from the existing CPD system and why was explained. The group undertook several exercises to enable them to become familiar with the content and process of the CFtP framework and to form and discuss their opinions on whether or not it provides assurance of fitness to practise.

### 9.2 Key Findings

#### 9.2.1 Exercise 1

The group was asked to consider a selection of recorded learning entries, selected from entries that pharmacy professionals participating in the pilot had submitted to the pilot database, including descriptions of planned and unplanned learning entries, case studies and peer discussions. Members of the group were asked to express their views as to the extent to which they felt these entries provided assurance of fitness to practice.

In particular they were asked to consider to what extent each learning record showed:

1. That the pharmacy professional has really thought about the needs of the patient or service user and how to provide them with a good service
2. That the learning process has been reflective (Members of the group were provided with the definition of reflective practice used by the GPhC: *"the critical evaluation of practice and learning to find ways to improve outcomes for patients or service users"*)
3. That the pharmacy professional has applied what they have learned and that they will ensure it makes a difference to their practice

They were asked to score each example entry, independently or in pairs, on how well these 3 elements were demonstrated.

- 1 - this is not demonstrated at all
- 2 - this is demonstrated to some extent
- 3 - this is very clearly demonstrated

A selection of examples for each the four different types of learning activity (planned learning, unplanned learning, peer discussion and case study) were given (see Appendix 11). The average scores for each example entry are given in Table 21 below.

**Table 21 Focus group scores for examples of recorded learning**

Example number	Type of learning	Score 1-3			Total score
		Q1 Patient centred	Q2 Reflective Learning	Q3 Applied Learning	
1	Planned Learning	2.8	2.2	3	8
2	Planned Learning	3	2.4	2.6	8
3	Planned Learning	2.5	3	3	8.5
4	Planned Learning	2	2	2	6
5	Unplanned Learning	3	3	3	9
6	Unplanned Learning	2.4	2.3	3	7.7
7	Unplanned Learning	1.7	2.3	2	6
8	Unplanned Learning	3	3	3	9
9	Case Study	3	2.4	3	8.4
10	Case Study	3	2.7	3	8.7
11	Case Study	2	3	2.8	7.8
12	Case Study	3	3	3	9
13	Peer Discussion	2.7	2.9	2.4	7.9
14	Peer Discussion	3	3	2.8	8.8
15	Peer Discussion	3	3	3	9
16	Peer Discussion	2	3	2	7
	All Planned Learning	2.6	2.4	2.7	7.6
	All Unplanned Learning	2.5	2.7	2.8	7.9
	All Case Study	2.8	2.8	2.9	8.5
	All Peer Discussion	2.7	3.0	2.5	8.2

The example learning records were further considered in a group discussion which focused on what factors gave the best evidence of fitness to practise. Key findings were:

- Examples that were clearly patient centred were preferred over those which were not. This was in relation both to wider examples and to examples that were service user centred.
- Where a registrant had reported a learning process from start to finish, including implementing learning and making changes to practice, gave most assurance that the learning had been effective
- Example 12, a case study, was particularly identified by all participants as an excellent record as it demonstrated customer service skills, showed clear reflection and gave an explicit example where the learning had been put into practise

### 9.2.2 Exercise 2

Having become familiar with recorded entries resulting from the four different types of learning activity (planned learning, unplanned learning, peer discussion and case study), the group members were asked to individually rate each type of activity between 1 and 3 where:

- 1 = not useful in providing assurance of fitness to practise
- 2 = of some use in providing assurance of fitness to practise
- 3 = very useful in providing assurance of fitness to practise

Out of a possible total score of 27 the scores for each activity type were:

Activity	Score	Rank
Planned Learning	25	1 <sup>st</sup>
Unplanned Learning	17	4 <sup>th</sup>
Peer Discussion	22.5	2 <sup>nd</sup>
Case Study	22.5	2 <sup>nd</sup>

Conclusions from the group discussion on the exercise were:

#### Planned Learning

The structure of the planned learning record requires more details to be provided by the learner and also results in measureable outcomes. Planned learning was viewed as the most useful type of learning

#### Unplanned learning

Although unplanned learning was seen as potentially useful in that it is often more challenging, can encourage proactivity and creative thinking in seeing a problem as a learning opportunity and can take learning in a new, unexpected direction, it was seen to be less measureable. Members of the group demonstrated less confidence in unplanned learning entries as a way of demonstrating learning and development than in the other types of entry. This was partly due to a view expressed that unplanned learning could be done at a small scale, and considered 'part of the day job' as opposed to a more formal and structured learning process on a larger scale. Unplanned learning was seen as the least useful type of recorded entry.

#### Peer Discussion

Making contact with other professionals and learning from others that this activity provides was judged to be very important by the focus group.

### Case Study

The value of case study entries was seen to be that they are real scenarios with measureable outcomes.

#### 9.2.3 Exercise 3

As an alternative way of assessing the value of the CFtP framework elements to the group, they were asked, 'if one activity type needed to be removed from the framework, which one would you choose?'

Unplanned learning was chosen by 6 out of 9 of the group as the element that they would drop from the framework, demonstrating that this was seen as offering less value to them in terms of demonstrating fitness to practice.

### 9.3 Findings against Desired Outcomes

#### 9.3.1 Outcome 7: The proposed approach is seen by stakeholders as providing assurance of fitness to practice

The focus group did feel that the CFtP Framework overall would give assurance to them of the fitness to practise of pharmacy professionals and the group expressed confidence in the robustness of the system.

The learning activities and subsequent recorded entries considered to provide most assurance were those that:

- clearly demonstrated applied learning and a change in practice
- were patient centred and showed understanding of patient needs

The entries that gave less assurance were those that:

- were focused on the individual pharmacy professional not on the patient or service
- did not show how the learning had been applied

Entries that were too technical and/or clinical were perceived as giving less assurance as the actual process and outcomes of learning, reflecting on learning and applying learning to practice became lost in the descriptions of technicalities.

Planned learning activity was thought to be the most beneficial and more likely to be patient centred, show reflective learning and result in implementation of the learning. Unplanned learning activity was thought to be the least beneficial.

The panel members wanted to know what the profile of the CFtP assessors was/would be, in terms of background and knowledge, how the entries were/would be assessed and how assessors judge validity of entries.

The discussion also examined whether registrants should be asked to prove the veracity of their entries in some way. Although most of the group strongly defended the integrity of the profession, there was some challenge to this given, and there was discussion about the implications of requiring pharmacy professionals to provide some evidence to support the veracity of their entries. In general, the addition of the peer discussion and case study elements to the learning requirements was thought to help improve the robustness of the

system, in part by bringing in a third party view in the case of peer discussions, and in requiring a demonstration of an actual change made to practice in the case studies.

The panel was informed that GPhC are separately looking at the assessment processes and that the feedback they had given would be provided to GPhC.

## 10 Comparison of the GPhC CFtP framework compared to that of other healthcare regulatory bodies

### 10.1 Introduction

Nine independent regulatory bodies<sup>4</sup> are responsible for the standards of practice of health care professionals in the UK. They register and regulate professionals and are overseen by the Professional Standards Authority for Health and Social Care (PSA). The regulatory bodies have a duty to safeguard the public by upholding and enforcing regulation in accordance with the statutory framework that has developed over many years in the UK. The legislation in this area is complex and the PSA has issued overarching guidance which allows for variation in approach by regulatory bodies. The PSA advocates “right-touch” regulation principles and recommends that regulators use “an approach to assuring continuing fitness to practise that is both proportionate and targeted”. They suggest that “regulators identify and quantify the risks presented by the professions they regulate in order to develop continuing fitness to practise (CFtP) mechanisms that provide them with the levels of assurance they need to mitigate these risks”<sup>5</sup>. As a result, different regulatory bodies in the UK have adopted varying approaches to ensuring fitness to practice.

Through the GPhC’s proposed CFtP framework for pharmacists and pharmacy technicians, with its requirements for evidence of planned learning, unplanned learning, peer discussion and case studies, the GPhC, like other health regulators, is seeking ways to further enhance assurance of fitness to practise in line with PSA recommendations. While there is much common ground across regulators, there are necessarily some areas of difference in the approach each takes. This section discusses some of the differences in the approaches taken by the regulators<sup>6</sup>.

### 10.2 Complexity

The PSA and the Department of Health advocate a targeted and proportionate approach to regulation and have confirmed with the GPhC, among others, that the complex approach adopted by the General Medical Council (GMC) is not proportionate or required for its registrants. The GMC’s approach, rolled out in 2012, requires full revalidation every five years in order for doctors to retain their license to practise. It requires doctors’ participation in local systems of annual appraisal and each doctor to have a link to a Responsible Officer (RO) who makes a recommendation to the GMC every five years regarding a doctor’s continuing fitness to practice. Doctors are required to complete CPD and quality improvement activity, review these and any complaints and compliments with an appraiser annually, as well as review a significant event and feedback from colleagues and patients once in every five year cycle. This approach reflects the high levels of perceived risk inherent in medical practice and highlighted by the Shipman Inquiry and the Bristol Inquiry which found major flaws in the way

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<sup>4</sup> The General Pharmaceutical Council, the General Medical Council (GMC), the General Dental Council (GDC), the , Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI), General Chiropractic Council (GCC), General Optical Council (GOC), General Osteopathic Council (GOsC) and the Health and Care Professions Council (HCPC)

<sup>5</sup> Council for Healthcare Regulatory Excellence, 2012. An approach to assuring continuing fitness to practise based on right-touch regulation principles. [www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/continuing-fitness-to-practise-based-on-right-touch-regulation-2012.pdf?sfvrsn=4](http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/continuing-fitness-to-practise-based-on-right-touch-regulation-2012.pdf?sfvrsn=4)

<sup>6</sup> Consolidated revalidation/continuing fitness to practise updates. Inter-Regulatory Meeting, 12th February 2016

doctors were monitored<sup>7,8</sup>. It is more complex than the approach adopted by other regulators, reflecting the particular need for reassurance of the public regarding doctors' fitness to practice.

### 10.3 CPD requirements

Some regulators have a much simpler model than that piloted by the GPhC and that adopted by the GMC, revolving around CPD activities alone (for example the Health and Care Professions Council (HCPC)), with varying requirements around the type of CPD, amount of CPD and recording and reporting of CPD. The GPhC's proposed model does not stipulate the number of hours of learning and development activity required but requires four CPD activities to be entered onto its CFtP database each year (at least two of which are planned) which meet certain criteria (such as being linked to improving practice). Some organisations stipulate a minimum number of hours of CPD with varying requirements around the types of CPD, as is the case for doctors, osteopaths and dentists. The CPD requirements for doctors are set by the Royal Colleges and vary by specialty, with the colleges monitoring the completion of adequate CPD. The GPhC, on the other hand, plans to monitor the completion of CPD by registrants itself, whereas the CPD activities tend to be provided by other professional and training organisations.

### 10.4 Other requirements (other than CPD)

The GPhC pilot CFtP model involves the addition of an annual case study and peer discussion (together with a reduction in the required number of recorded CPD activities compared to its current system). The GMC has a number of additional requirements detailed above. The General Chiropractic Council (GCC) and General Osteopathic Council (GOC) are planning to introduce an element of peer discussion. The Nursing and Midwifery Council (NMC) requires that registrants practice for a minimum number of hours, obtain feedback about their practice and have a reflective discussion with another NMC registrant. Some, including the GPhC, also require registrants to make health and/or character declarations.

### 10.5 Centralisation of monitoring

GPhC registrants are required to keep all records relating to professional fitness to practise centrally, so that these can be assessed by GPhC assessors. This is similar for the HCPC and for chiropractors and dentists but different, for example, from the local appraiser and responsible officer model of the GMC. For others there is a mixed model with some elements being more localised. For dentists, for example, development plans and training needs are to be established locally. Osteopaths are currently discussing a decentralised system mainly through peer review.

### 10.6 Remediation

The GPhC plans that remediation will continue to be part of its CFtP framework. It can impose remedial measures, although where a professional then goes for help will be up to them and it might be their employer, a postgraduate education provider or a professional body. Some

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<sup>7</sup> Learning from tragedy, keeping patients safe. Overview of the Government's action programme in response to the recommendations of the Shipman Inquiry, 2007. London Stationery Office. [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/228886/7014.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228886/7014.pdf)

<sup>8</sup> The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995 Learning from Bristol, 2001. [http://webarchive.nationalarchives.gov.uk/20090811143745/http://www.bristol-inquiry.org.uk/final\\_report/the\\_report.pdf](http://webarchive.nationalarchives.gov.uk/20090811143745/http://www.bristol-inquiry.org.uk/final_report/the_report.pdf)



regulators, such as the GMC and the NMC, stipulate that employers must have processes in place for remediation.

### 10.7 Frequency / cycle length of CFtP process

Continuing fitness to practise is likely to have an annual cycle for pharmacy professionals. It is a 5-year cycle for doctors, with annual appraisal, the same for dentists but with annual returns, a 3-year cycle for nurses and midwives and annual cycles for chiropractors. Osteopaths are consulting on an annual self-declaration with sign-off every three years. HCPC has a 2-year cycle of random audits.

### 10.8 Reflection

The GPhC has built reflection on learning and on the impact of learning and how it will improve patient and service user outcomes into its CFtP pilot framework. A number of other regulatory bodies have also built in a requirement for reflection, for example the NMC and GMC require reflective accounts of CPD and a reflective discussion and the HCPC requires that for a small number of CPD activities the registrant describes how the CPD benefited their practice and service users.

### 10.9 Assessment / Revalidation versus Continuous Improvement

As with the previous system, the GPhC plans to continue to appoint assessors to assess registrants' CPD, case study and peer discussion entries to ensure that they are linked to improvements in practice. Other models include the use of appraiser and RO (model used by the GMC), who influence the revalidation of a registrant. Similarly, in the NMCs model, the registrant needs to discuss and demonstrate to an appropriate confirmer that they have met the revalidation requirements before submitting their revalidation application to the NMC online. Regulators, including the GPhC, also have a separate system for dealing with fitness to practise issues that arise from complaints.

### 10.10 Discussion

The GPhC's direction of travel is to move away from a process of a fixed point assessment for assurance

“based on affirming the core standards for safe and effective pharmacy practice on a continuous basis by driving behaviours toward engagement with professional responsibilities for maintaining and developing professional knowledge and skills through reflection and collaboration.”<sup>9</sup>

Given the PSA guidance on the CFtP model being proportionate to risk, this makes sense. It may also lead to a more open and hence productive peer discussion that leads to improvement in practice, because the peer is not assessing or reporting to the GPhC on the registrant's fitness to practice. This evaluation of the GPhC pilot model set out to determine whether this is likely to work effectively in practice.

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<sup>9</sup> Continuing Fitness to Practise. About the pilot.

<https://www.pharmacyregulation.org/registration/continuing-fitness-practise> (accessed Feb 2017)



## 11 Recommendations

Feedback on the CFtP pilot was generally very positive. However, suggestions were made which should be considered before rolling the system out to all pharmacy professionals. In addition, recommendations have been made as a result of the analyses carried out as part of this evaluation. The majority of these have previously been detailed in the relevant sections, whereas some are overarching and so presented here only.

Some of these were referred to many times by different respondents whereas others may have been raised by a much smaller number of people. Similarly, some suggestions relate to the framework as a whole, whereas others relate to very specific issues. It is recommended that the GPhC considers these recommendations in conjunction with the detailed analyses presented in this report.

### 11.1 Communication Channels and Materials

1. Prior to roll-out, a mix of communication channels should be used to explain the proposed system, recognising that individuals have different learning styles, and allowing them to fit their learning about the proposed system around their own working patterns. This could include the following, a number of which proved to be popular during the pilot period:
  - a. Road shows or similar events
  - b. Webinars: live and short recordings
  - c. Help desk
  - d. User group (virtual and/or physical)
  - e. Web based user forum
  - f. Regional or local “champions”
2. Continue with some of these communications during and subsequent to roll out of the proposed system, and gather ongoing feedback regarding their effectiveness
3. Consider using a range of materials such as guidance documents and leaflets, and make material available via the software used in an intuitive, unobstructive way, which is searchable for ease of use where appropriate
4. Review ways to ensure the guidance remains accessible and encourages users to read through it, while maintaining the level of detail needed. This may be possible through providing information in different ways, such as the guidance documentation, prompts within the system as noted below, searchable FAQs etc.
5. Provide a short explanatory leaflet (electronic and hard copy) for pharmacy professionals to give to prospective peers which includes what the CFtP process is, what is expected of peers and tips on how to give feedback constructively
6. A printable proforma may be found helpful for pharmacy professionals to use to write down notes while carrying out their peer discussion, highlighting key requirements as an aide-memoire
7. Consider showing the CFtP steps via a flowchart
8. Ensure that any changes to communication materials and channels are tested prior to use

## 11.2 Messages relating to the framework

1. Communicate the positive impacts for pilot participants of using the CFtP system, such as its speed and ease of use, and the ability to record a narrative, to encourage engagement
2. Articulate the potential benefits of completing case studies and peer discussions more clearly, including using positive messages received through this evaluation, to encourage engagement
3. Ensure that pharmacy professionals are aware of the assessment processes that are to be part of the CFtP system and that these processes are aligned with the guidance given to registrants
4. Communicate the positive feedback received considering the robustness of the proposed framework and the assurance it provides, monitor future feedback on this and consider the advantages and disadvantage of further reducing the reliance on trust in the future
5. Suggestions were made as to how the framework could be extended to serve additional purposes, for example to allow recording of identified future learning needs, to allow it to act more as a lifelong learning portfolio. It is recommended that such ideas are recognised, and reasons given for any decisions as to their being taken forward or not
6. Communicate the potential impact of the new framework clearly to employers, to encourage their engagement
7. Consider appropriate communications to other stakeholder groups
8. Consider limiting the requirement to reflect the GPhC Standards in the case study to Standard 3 – Communicate Effectively, for some time after the full roll out of a new framework, to reduce the complexity of the concepts and messages which need to be communicated

## 11.3 Clarification of the Guidance

1. It is suggested that further clarification is given via the guidance to participants relating to a number of issues, detailed here. It should be noted that some suggestions for elements for inclusion in guidance are shown in the current guidance, but evidence suggests they have not been understood fully by participants. Therefore both the messages given and how they are understood by participants should be tested prior to use
2. Ensure that all elements of guidance documentation are aligned and consistent
3. Provide examples of entries that relate to a wider range of work settings and roles
4. Provide further clarification around the meaning of the term “service users”
5. Provide guidance as to the level of technical detail that is expected. This should link to the assessment processes which are being determined separately and do not form part of this evaluation
6. Consider providing guidance as to the maximum length of time and/or the length of entries required. This must take into account the risk of reducing the amount of entries

people make where they would otherwise enter far more than the minimum required and/or reducing the amount of information they provide in each entry. Communications would therefore need to address this. It would also need to be made clear that there was no associated expectation of any reduction in learning and development activities, or any desire to inhibit people from carrying out more learning and development activities than they record

7. Ensure that the reasons for requiring each type of learning entry are clear
8. Ensure that the specific requirements of each entry type are clear. For example, the GPhC guidance for case studies states "The topic you select for your case study should be different to the topics selected for your CPD submissions." This requirement was not stated for peer discussions, and not explained
9. Ensure that the differences between each type of entry are clear, as some participants were unclear whether a particular example would be most suited for use as a case study or planned/unplanned learning entry
10. Clarify the need for activities to be relevant to one's role and the need to demonstrate the relevance
11. Clarify the need to document the rationale behind the choice of peer and provide further guidance on how to choose a peer according to one's needs
12. Ensure that the participants understand that peers do not have to be pharmacy professionals
13. Provide a more specific explanation of what is meant by a "case study"
14. Consider using a different term for a "case study" or clarify that it does not refer to a clinical case study per se. Possibilities are: "an example of a change in practice in relation to standards"; "a reflective account of a change in practice in relation to standards"; "improvement in practice in relation to standards", "change to practice that has benefitted patients or service users"
15. Explain the reasons for focusing on the GPhC Standards in the case studies, and make explicit that any CFtP entries may be used to demonstrate activities related to standards, but that the difference with the case studies is that this is a requirement
16. The guidance around case studies states: "We want you to reflect on the change itself and, if possible, include information on how you have evaluated this impact." A clearer expectation may be that participants are asked to demonstrate a change they have made to their practice which has benefitted patients or service users, and to describe what they consider to be the impact of this change, including any evidence if available. It may also be helpful to explain to participants that this change does not need to have resulted directly from a learning or development activity, but rather is aimed at their demonstrating that they are engaged in a cycle of continuous improvement of the service they provide to patients or service users.
17. Provide a more specific explanation of what is meant by a "peer discussion", and ensure the term "peer discussion" is differentiated from the term "peer review"
18. Provide further guidance around identifying an appropriate topic for a peer discussion

19. Review the wording of guidance for case studies especially, and also for peer discussions, to ensure it is fully and clearly aligned with the objectives of these entry types
20. Acknowledge similarities and differences with the Royal Pharmaceutical Society's professional development programme and other similar systems and frameworks, and explain how these should inter-relate
21. Review the guidance around the use of different tenses for planned learning entries as this was found confusing by some
22. While participants are likely to carry out a lot more learning activities than are entered onto the framework (and should not be discouraged from doing so), and some learning may not result in a change in practice but may rather support the status quo, the entries in the CFtP system should be examples of learning that have resulted in a positive change, and this could be made clearer in the guidance
23. The timing of entries may need clarification if measured impacts are to be documented (i.e. entries made once impacts have been realised). Alternatively, multiple entries could be required (i.e. at the time of learning, at implementation of learning and following implementation) in order to assess learning and impacts

#### **11.4 Making best use of the software used**

1. Make the definition of “reflective learning” and the GPhC standards as well as the meanings of terms such as “service users” easily accessible within the system, and consider adding prompts to remind users within the system
2. Make the full guidance easily accessible within the form that is filled in, for example by slightly lengthening the questions and/or through drop-down help boxes that can be read by those who wish to
3. Ensure that participants can go back to and update entries, particularly to add information on benefits seen, and consider adding reminders/prompts for participants to return to entries if benefits occur later
4. Include prompts within the system. These could appear at relevant points to remind people of the key requirements of a particular section. Another option may be to make the questions asked slightly longer to include relevant point
5. Review the comments made regarding issues found with the pilot software, particularly via the online survey, to ensure issues are addressed going forward

#### **11.5 Supporting Fairness and Equity**

1. Consider reasons for lower participation rates in some groups (pharmacy technicians and people of Indian ethnicity and possibly also locums and disabled) and what can be done to support them further
2. Consider support for those working in isolated busy posts, particularly in finding suitable peers for peer discussions, as well as support for those who have recently changed roles and so not had the opportunity to build networks from which to identify a peer

3. Continue to monitor engagement with the system as it is rolled out and ensure that some of the groups that had lower participation rates in the pilot are supported to and do participate
4. Work with employers to ensure that more support is provided where possible particularly to encourage participation in groups where this has been found to be lower
5. Whilst analysis of online survey responses showed no clear trends of any particular groups being advantaged or disadvantaged systematically, there were some findings of interest relating to specific areas. These should be reviewed in detail to inform future communication strategies



## Appendix 1 Glossary

CFtP	Continuing fitness to practise
CPD	Continuing professional development
CPPE	Centre for Pharmacy Postgraduate Education
GCC	General Chiropractic Council
GDC	General Dental Council
GMC	General Medical Council
GOC	General Optical Council
GOSc	General Osteopathic Council
GPhC	General Pharmaceutical Council
HCPC	Health and Care Professions Council
NMC	Nursing and Midwifery Council
PSA	Professional Standards Authority for Health and Social Care
PSNI	Pharmaceutical Society of Northern Ireland
RO	Responsible Officer
RPS	Royal Pharmaceutical Society
SPH	Solutions for Public Health



## Appendix 2 Phasing of key evaluation project activities

Activity	Phase 1 description	Phase 1 timescale	Phase 2 description	Phase 2 timescale
<b>Online survey</b>	Tested with 10 participants. Sent out to participants who had completed all entries	Survey response cut-off date: 4 <sup>th</sup> November	Sent to remaining participants	Survey closed January 5 <sup>th</sup> 2017
<b>Focus group – patient representatives</b>	One-off activity, therefore not phased			
<b>Analysis of records entered into pilot system</b>	Analysis of sample of records where participants have completed all entries	By 7 <sup>th</sup> October	Analysis of second sample of records where participants have completed all entries, by mid-December, plus additional small sample of late-completed entries	By 18 <sup>th</sup> January 2017
<b>Phone interviews – pharmacy professionals</b>	Completed for identified participants who had completed all entries	By 4 <sup>th</sup> November	Completed for remaining identified participants who had completed all entries	By 16 <sup>th</sup> December
<b>Phone interviews – employers</b>	Completed for identified employers	By 4 <sup>th</sup> November	Completed for remaining available employers	By 16 <sup>th</sup> December
<b>Phone interviews – Peers</b>	Completed for identified Peers	By 4 <sup>th</sup> November	Completed for remaining identified Peers	By 16 <sup>th</sup> December
<b>Phone interview – External perspective</b>			Carried out after phase 1 of other interviews, to build in learning from these	By 9 <sup>th</sup> December

## Appendix 3 Analysis of entries – statistical analysis explained

Statistical analysis has been conducted using 95% confidence intervals (the error bars shown on the charts). This method gives a range around the sample estimate in which we are 95% confident that the true population value lies.

[Here the *sample* is the CPD entries that have been analysed as part of this evaluation and the *true population* is the all the entries completed as part of the pilot study].

For example, a sample estimate of 75% with a 95% confidence interval of 69%-88% means that our best estimate for the proportion in the total population is 75%, however, the true value could lie anywhere between 69% and 88% (95 out of 100 times if a sample were to be taken 100 times).

Using this method, we can assess the significance of differences between population groups. If the confidence intervals around two separate estimates are overlapping, we can say that any observed differences may not be true differences and could be due to chance alone.

For example, considering the following:

77% of women answered a question well, with a 95% confidence interval of 69%-88%

60% of men answered a question well, with a 95% confidence interval of 44%-75%

Although it first appears that women may give better answers than men, this result is not statistically significant because the true proportion for women may be as low as 69% and the true proportion for men may be as high as 75%. In this case we cannot conclude that there is a difference between how well women and men answered the question.

In contrast, where confidence intervals do not overlap, we can be 95% sure that the observed difference between estimates is in fact a true difference.

For example, considering the following:

77% of women answered the question well, with a 95% confidence interval of 73%-78%

60% of men answered the question well, with a 95% confidence interval of 58%-62%

In this case the lowest value around the estimate for women does not fall within the range of estimates for men; therefore the difference we have observed is likely to be a true difference between men and women in the population.

Finally, the accuracy of the sample estimate depends on the size of the sample taken; the bigger the sample, the more likely it is to give a true representation of the total population. Larger samples have smaller confidence intervals as we are more sure that the estimate reflects the true population value (the estimate is more precise).

Within the analysis conducted for this evaluation, some sub-groups have very low sample sizes; for example only 2 pharmacy professionals working in hospice care undertook a peer discussion. With very low sample sizes, the confidence we have in the estimate is low (wide confidence intervals). Here we are unlikely to observe statistically significant differences between groups. However, it will be important to review this finding in the future to identify any differences when the sample size is increased.



## Appendix 4 Guidance issued to CFtP Pilot Volunteers

# 1. Guidance for pilot volunteers (April - December 2016) v1.0

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## Section 1: About this guidance

This document is for volunteers piloting new ways to further assure that pharmacists and pharmacy technicians meet standards for safe and effective practice throughout their careers.

In this document, when we use the term 'we' or 'us' this includes:

- the General Pharmaceutical Council
- staff employed by the Council

In this document, when we use the term 'you' this means:

- a pharmacist
- a pharmacy technician

In this document, when we use the term '**patients or service users**' this means any person receiving services from a pharmacist or pharmacy technician. The term is deliberately inclusive so that it is relevant to all pharmacy professionals whether they directly interact with patients or not. The term includes, but is not limited to:

- patients
- carers or family of patients
- health professional colleagues
- non-health professional colleagues
- students or trainees, and
- organisations.

This guidance sets out:

- an explanation of why and what we are piloting
- how the pilot will work and what it means for pilot volunteers
- how volunteers should complete entries in a new online recording tool.

This guidance is currently a draft designed to support volunteers in participation in the pilot, and will be subject to amendment following evaluation. This draft (v.1.0) is not formal agreed policy of the Council.

## Section 2: About the pilot

In 2018, the GPhC plans to introduce new arrangements to further assure that pharmacists and pharmacy technicians meet standards for safe and effective practice throughout their careers.

We have been developing our proposals over the last few years through research and testing. We are now in a position to pilot these proposals with a wider group of pharmacists and pharmacy technicians so that we can better understand their impact.

As a pilot volunteer you are playing a very important role in helping us understand if our proposals:

- will work as we intend them to
- lead to any unintended consequences, and
- can be improved before we consult upon them in 2017 and implement them in 2018.

### Why we are piloting new arrangements

Pharmacy professionals already provide assurance of their ability to meet standards for safe and effective practice on a continuous basis through annual renewal of registration and undertaking and recording continuing professional development (CPD) activities.

We know from a number of different sources that members of the public would like to have further assurance that health professionals (including pharmacy professionals) are safe and effective beyond initial registration. To meet this expectation we have been trying to understand what pharmacy professionals already do to maintain and develop their knowledge, skills and practice to find out how these might be used to provide that further assurance. In our last year of work we learnt that we can do more to encourage reflection on learning and practice in some innovative ways and are now in a position to pilot these with a wider group of volunteer pharmacy professionals.

### When we are piloting

We will launch the pilot in April 2016 and run it through to December 2016. Over this time, volunteers will be making entries in a new online recording tool. From August 2016 we will be making contact with volunteers to start evaluating how things are working. In January 2017 we will start collating the information we have received and use it to form the basis of consultation proposals which would be taken to our Council in March 2017. The consultation would run following that meeting for three months.

If we decide to make changes to how we work following consultation, we will ensure there is appropriate time to communicate the changes and for individuals and organisations to adapt.

## What we are piloting

We are piloting:

- a simplified recording approach for CPD,
- a peer discussion
- a case study

These will be completed in an online recording tool. You will receive an email with a link to the online recording tool.

## Our proposal for changing CPD

We learnt last year that increasing ease, immediacy and accessibility of recording would make it more likely that pharmacy professionals would reflect closer to the time of a learning activity and more effectively. We also discovered that we could ask fewer questions of registrants and achieve a better outcome which was more focused on the difference that learning activities had on patients or other service users.

Volunteers will be asked to record four entries in the simplified recording tool. There will only be two “starting points”: planned and unplanned. We are asking that a minimum of two of the entries are planned. Depending on the starting point there are two to three boxes to fill in with information about the CPD activities.

## Our proposal for introducing peer discussion

We want to encourage pharmacy professionals to engage with other people in their reflection on learning and practice. This is proven to be an effective way to help people improve practice. We expect that encouraging peer discussions will also reduce the likelihood of professional isolation.

In our testing last year we discovered that there are important characteristics for a reflective discussion which we want to learn more about in the pilot. To be most effective, these discussions should be formative, open and honest and with someone who is trusted and respected.

We expect peer discussions to happen in lots of different ways: one-to-one, in groups, virtually or over the telephone, through employer led schemes, as part of a local or national network or as a result of other development activities such as a professional body scheme. We also know that peer discussions may take place with other pharmacy professionals, other healthcare professionals or potentially with someone outside of healthcare but with a similar role.

All of these approaches seem to have merits and in piloting we want to explore them all. The content of the discussion will remain confidential but we will ask volunteers to record the details of their peer(s) and to let us know about the difference it has made to their practice.

## Our proposal for introducing case studies

Our approach to CPD encourages reflection on learning, but we also want to do more to encourage reflection on practice based on evidence.

The case study asks pilot volunteers to describe an example of a change to practice related to one of our new draft standards for pharmacy professionals. We want to see how pharmacy professionals are reflecting on their practice and making changes for the benefit of patients or service users. We expect there to be a diverse range of ways that pharmacy professionals will respond to the case study, with some telling us about a particular moment in their practice where they responded to a need of patient or other service user, others telling us about evidence collected in practice driving a change, or some even relating the change to new evidence emerging from research conducted by themselves or others.

## How we will evaluate our proposals

The pilot provides the opportunity to understand how our proposals will work in the context of real pharmacy practice. For this reason, we have recruited volunteers from across the many diverse roles and contexts of pharmacy practice.

We will be:

- looking closely at how volunteers participate and if that provides the further assurance we want to achieve
- understanding the impact on time and cost to individuals and the sector
- considering how different groups of registrants interact with the proposals differently (such as between countries, employment types, or protected characteristics)

Because we want to make sure our proposals are thoroughly tested, we will be appointing an independent evaluator who will collect, analyse and report on the data we collect.

As part of the evaluation, we will take a sample of the volunteers and ask our CPD reviewers to review the records that have been submitted. This will help us develop assessment criteria and also make a judgement about how we can provide feedback to you when we come to implement any proposals. If you are selected for the sample, you will receive some feedback based on your submitted entries.

## Section 3: How the pilot will work

### Who can participate in the pilot

The pilot is designed to help us understand the impact of our proposals on those who will be affected by them. We have selected currently registered pharmacists and pharmacy technicians to participate from a range of roles and settings of practice that is representative of pharmacy as a whole.

This means we are not including students or pre-registration trainees in the pilot as our future proposals are not intended to be applied to them. We are however including recently registered pharmacy professionals to understand how someone who has recently completed their training will be able to engage with the proposals.

### What participation means for volunteers and current CPD requirements

If you are selected for the pilot you:

- be exempt from calls for CPD records in 2016 and 2017 (although some of you may have been called and submitted already)
- normally, be exempt from having to record CPD in [uptodate.org](http://uptodate.org) under our previous requirements. However, in some cases we may need to require you to record CPD under our current requirements as well. You will be informed via email if you are required to continue recording under our current requirements
- will be asked to undertake activities and complete entries in the online recording tool
- will be asked to participate in surveys and possibly interviews so that we can understand more about how the proposals have impacted you
- The pilot does not replace or override the GPhC's existing procedures for dealing with concerns about registrants' fitness to practise. If concerns are raised with us, we may make the decision to ask you to leave the pilot and return to recording entries under our current CPD requirements

### How to participate – what happens and when

The email you received that contained this guidance document also holds all the information you need to start working towards producing submissions to record your CPD activities, a peer discussion and a case study.

In your email you will have a link to the pilot online recording tool in which you can start preparing your new entries. When you follow that link you will arrive at a page where you can choose to record new entries either as:

- planned CPD
- unplanned CPD
- a peer discussion
- a case study

In May 2016 we will also be distributing a further link to an online workshop where you will be able to ask questions, propose improvements and generally feedback on how things are going. We plan to keep this workshop open for a month, but may extend this if it proves a useful tool to support piloting.

In August 2016 we will be contacting you again to start the process of evaluation. You will be asked to complete surveys and you may be asked to participate in interviews or focus groups as well.

In September 2016 we will randomly select a proportion of the pilot volunteers and ask our CPD reviewers to consider their entries them to help us understand if our proposals are effective and to consider what kind of assessment criteria we might want to use in future. Please note, this review is purely for research and development purposes.

In November 2016 we will remind you that the pilot will shortly be finishing and that you need to complete your entries. Please do make sure you participate as we will need to require anyone who does not to return to recording CPD under our current requirements and include them in the call of CPD records in 2017.

In December 2016 the pilot will close and we will work to analyse the findings.

From January to March 2017 we will share our findings with you as well as a high level feedback report looking across how people participated. Though we cannot offer bespoke feedback to everyone in the pilot at this point, this high level report will provide insight into how people did on a general basis and be relatable to your own future development.

If you can't find the information you need in the materials we have provided, then you can email us at [cftp@pharmacyregulation.org](mailto:cftp@pharmacyregulation.org)

## Section 4: How to complete and submit entries

This section of the guidance outlines how to complete and submit entries in the pilot recording tool. You will find technical advice about how to use the recording tool and guidance on how to make good entries. There is also some additional guidance about undertaking and recording activities which it will be helpful to read before you start to make entries. On pages 12-15 there are example forms for recording with guidance on what to record. We have also produced example entries to help you understand what a good entry looks like. These have been provided as a separate document and are also available on our website.

### Pilot recording and submission requirements

The recording and submission requirements are:

- Use the online recording tool. We are not planning to accept paper submissions. Contact us if this is a problem for you at [cftp@pharmacyregulation.org](mailto:cftp@pharmacyregulation.org)
- Complete **four** CPD entries by December 2016, of which a minimum of **two must** be planned learning activities
- Complete **one** peer discussion entry by December 2016
- Complete **one** case study entry by December 2016
- Your entries should relate to the context of your practice
- Your entries should relate to activities that you have completed, because we want you to give examples of the difference the activities have made to your practice

### Using the online recording tool

The online recording tool is a prototype solely to be used in piloting. If we make changes to the way we work we will develop a more permanent tool based on this simple version.

The link you receive in your email can be used repeatedly to make your entries. Below are some instructions for using the tool. You can:

- return to the same link as many times as you want to make entries.
- save entries part way through and return to them at a later date. An email will be sent to your account with a link to allow you to resume your entry
- download a copy of each entry once it is completed and submitted.
- receive an email with a copy of each entry once it is completed and submitted

Some **important** things to know about using the online tool are:

- each recording form is made of a single screen. If you hit "NEXT" your entry will be completed and submitted. If you do this in error, please email [cftp@pharmacyregulation.org](mailto:cftp@pharmacyregulation.org) with your registration ID and the approximate time and date and we can delete the incorrect entry.
- please ensure you type your name and registration number correctly so that we can join all of your entries up. Errors might mean we need to contact you to confirm an entry is yours.



## Undertaking and recording CPD

There are two ways that you undertake CPD:

- **Planned learning** – when you decide to develop your knowledge and or skills in advance of undertaking a learning activity.
- **Unplanned learning** – when an event occurs that causes a learning activity.

We want to see that you are planning some of your learning so we ask that you record a minimum of two planned learning activities. You may record all of your entries as planned learning if you wish, but we also recognise that learning takes place all the time and in different ways and may not be planned. For planned learning entries you may want to start the entry and then return to it later after you have undertaken the activity and applied the learning.

We want to see the **relevance** and **breadth** of your learning and development activities. Your learning activities should be relevant to your practice, so you should record activities that relate to the work that you do. The methods you use to learn should be varied depending on what you are learning. Therefore, though you might learn new knowledge from reading a journal, only reading journals would not be appropriate to learn certain things, such as applied skills. Therefore, across your four entries you should record activities that relate to your practice and attempt to learn using a variety of methods.

## Undertaking and recording a peer discussion

Peer discussion is a powerful tool to aid reflection on your learning and practice. For your peer discussion to be effective you need to consider the following things:

- locating an appropriate peer or peers
- sharing relevant information to guide the discussion
- undertaking and responding to the discussion in a reflective way

There are different types of peer discussion and only you will be able to determine which type would be most effective for you. Some types of peer we have seen to be effective in prompting discussion are:

- a trusted colleague
- a line manager
- a group of peers
- a mentor or coach

For many of you the most effective peer relationship would be with another pharmacy professional. However, for some of you, it may be appropriate to consider a peer from another health profession or possibly someone who is not a health professional but has insight into the kind of work that you do (for example, some pharmacy leaders may consider seeking out someone in another leadership role who is not a pharmacist).

Your peer should be someone who understands the work that you do and someone that you respect and can trust. This might mean it is someone you work with, or a group of people with similar roles to you, or someone with the same or similar professional background.

You might find your peer(s) through:

- your employer (and your peer may or may not be your line manager)
- an education and training provider
- a professional body or association
- local or national networks

If you are having trouble locating a peer, please contact us at [cftp@pharmacyregulation.org](mailto:cftp@pharmacyregulation.org) and we can assist you in finding an organisation that may be able to help you.

Before your peer discussion you should consider sharing information to make sure the conversation is effective. You should consider discussing your CPD activities and your case study (particularly if you have yet to decide what they might be). You might also want to discuss other pieces of information about your practice, such as:

- quality improvement activity
- significant events
- review of complaints and compliments
- feedback you receive from patients or other service users
- performance and development reviews
- the [standards for pharmacy professionals](#) (draft out for consultation April to June 2016)

The discussion should be formative (your peer is not making an assessment of you). The discussion is intended to aid your reflection so your peer will ask you questions about you and your practice to help draw out reflections you might not have reached on your own. Please share this guidance document with your peer to let them know what to expect, particularly as we will also be contacting some peers to understand about the impact our proposals have on them as well.

## Undertaking and recording a case study

Our approach to CPD encourages reflection on learning, but we also want to do more to encourage reflection on practice based on evidence.

We want you to produce a case study of a change to your practice that has benefited your patients or service users. The topic you select for your case study should be different to topics selected for your CPD submissions and should specifically relate the example to Standard 3 'Communicate effectively' of the draft [Standards for Pharmacy Professionals](#). We want you to reflect on the change itself and, if possible, include information on how you have evaluated the impact.

If you have made a change to your practice that has not had any beneficial impact on your patients or service users please select a different topic for your case study.

You may find it helpful to discuss what to include in your case study as part of your peer discussion.

Do not forget to look at the example of a case study we have provided as part of the information in your introductory email.

## CPD planned learning exemplar form and guidance

### 1. What are you planning to learn?

Tell us what learning you are planning to undertake. What you need to learn may be new knowledge, skill(s), or a new attitude - anything which you think will make you better able to do your job as a pharmacy professional or prepare you for a new service or role. You should be as specific as possible.

You should explain why this learning is relevant to you in your role as a pharmacy professional and how it will affect your patients or service users. If you don't think it is relevant or will not have a significant beneficial impact on anyone, you might want to consider why you are undertaking and recording this learning.

### 2. How are you planning to learn it?

It is important for you to consider a range of options for achieving your learning across the breadth of your CPD entries. Focus your planned CPD on those activities that are relevant / likely to have the biggest impact on your patients or service users.

### 3. Give an example of how this learning has benefited your patients or service users.

Putting learning into practice is a good way to prove that you have actually learnt what you set out to. Tell us what specific skill, attitudes and / or behaviours you have gained as a result of your learning.

Include an example of how your patients or service users have benefited from your learning. If you were able to introduce a new service successfully, the benefits will be clear. If you are more confident in your ability to respond to a particular query or have some new knowledge that you can use in your practice that is also a beneficial outcome.

Do include any feedback about your practice that you have had from other people.

## CPD unplanned learning exemplar form and guidance

**1. Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills.**

Tell us about the event or activity. Be specific about the event or activity you describe. If you read an article give it a reference.

Tell us what you learnt from the event or activity in terms of the skills, knowledge, attitudes and/or behaviours you have adopted.

**2. Give an example of how this learning benefited your patients or service users.**

Include an example of how your patients or service users have benefited from your learning. If you are able to introduce a new service successfully, the benefits will be clear. If you are more confident in your ability to respond to a particular query or have some new knowledge that you can use in your practice that is also a beneficial outcome.

Do include any feedback about your practice that you have had from other people.

## Peer discussion exemplar form and guidance

**1. Please provide the name, contact details and the role of your peer on this occasion.**

Name of peer:\*

Peer's role:

Name of peer's organisation:

Peer's contact number:

Peer's contact email:

\*If you participated in a group peer discussion, please only provide the name of one person from the group.

**2. Describe how this peer discussion changed your practice for the benefit of your patients or service users.**

Give an example of how this peer discussion has helped you to reflect on your practice.

Tell us what change you may have made to your practice as a result of this peer discussion and the beneficial outcomes for your patients or service users as a result of this change.

Do include any feedback about your practice that you have had from other people.

You are not required to include information on the subject(s) discussed if you feel the contents are confidential.

## Case study exemplar form and guidance

1. **Give an example of a change you have made to your practice this year in the context of Standard 3 of the [draft] *Standards for Pharmacy Professionals* that has benefited your patients or service users.**

Tell us about a change to your practice related to Standard 3 'Communicate effectively'.

Describe how the change you have made has benefited your patients or service users.

Tell us, if possible, how you have tried to evaluate the beneficial impact.

Do include reference to any objective evidence you may have collated that relates to the beneficial impact of the change, for example, user surveys, questionnaires, audits, incident logs.

Do include any feedback about your practice that you have had from other people.

We recognise that evaluating the beneficial impact of some changes may be easier to do in some scenarios than others. If you have not yet had the opportunity to evaluate the beneficial impact of the change in practice you have selected for the purposes of this case study, tell us why and describe types of processes you might consider.

## Section 5: Data Protection and confidentiality

### Patient confidentiality

Pharmacy professionals have a duty by law and under the GPhC's [draft] Standards for Pharmacy Professionals not to disclose confidential information about patients without their consent unless required to do so by the law or in exceptional circumstances. Please take care when you are referring to issues concerning specific patients within a CPD entry to make the information anonymous or to use coded information.

### Our use of your personal data: the GPhC's data protection statement:

The GPhC is a data controller registered with the Information Commissioner's Office. The GPhC makes use of personal data to support its work as the regulatory body for pharmacists, pharmacy technicians and retail pharmacy premises in Great Britain. Data may be shared with third parties in pursuance of the GPhC's statutory aims, objectives, powers and responsibilities under the Pharmacy Order 2010, the rules made under the Order and other legislation. Personal data may be processed for purposes including (but not limited to) updating the register, administering and maintaining registration, processing complaints, compiling statistics and keeping stakeholders updated with information about the GPhC. Information may be passed to organisations with a legitimate interest including universities and research institutions. Please note that the GPhC will not share your personal data on a commercial basis with any third party.



## Section 6: Contact us

Please email us if you require further information or have any queries relating to this pilot:

[cftp@pharmacyregulation.org](mailto:cftp@pharmacyregulation.org)

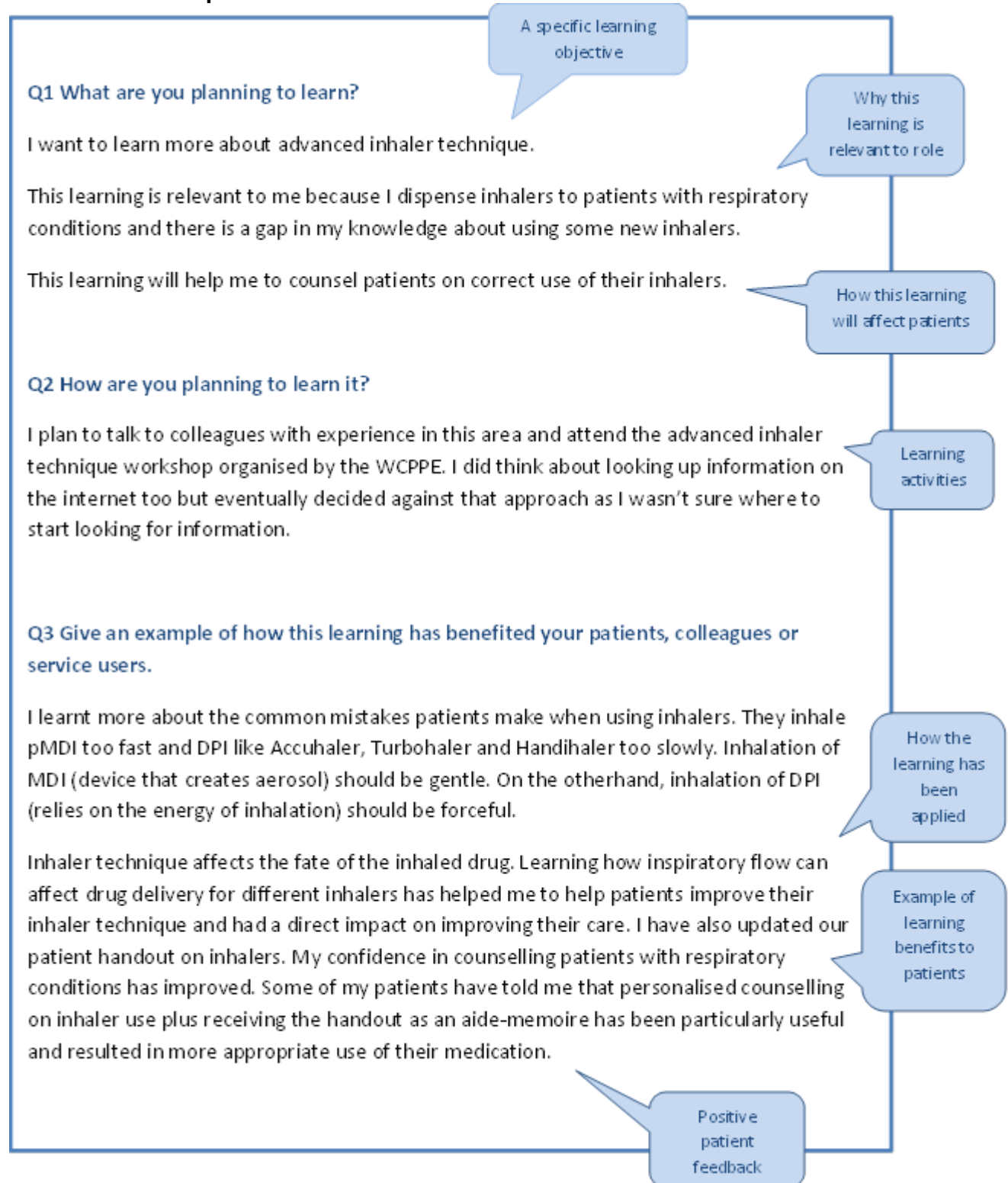
If you have difficulty finding a peer or need to reconsider your involvement in the pilot, for example, due to illness or family leave, please contact us as soon as possible.

## 2. Example entries for piloting CFtP

### Examples of completed forms

This document provides examples of CPD, peer discussion and case study forms that we consider good. The speech boxes illustrate the qualities that make the entries stronger. We have tried to provide examples across a range of roles and settings of pharmacy practice so that they are relevant to you no matter where you work.

## Planned CPD -Hospital



## Planned CPD - Community

A specific learning objective	Why this learning is relevant to role
<p><b>Q1 What are you planning to learn?</b></p> <p>More about the abuse or misuse of over the counter (OTC) medicines. At busy times I sometimes serve customers at the front counter and have noticed that some customers are coming in regularly and asking for the same products again. I have been asked by the pharmacy manager to monitor the supply. I want to learn more about what to look out for when a customer keeps asking for the same medicine and refresh my knowledge of those medicines that may possibly be subject to abuse or misuse. The learning will hopefully benefit customers as it will help to avoid inappropriate supply.</p>	<p>How this learning will affect patients</p>
<p><b>Q2 How are you planning to learn it?</b></p> <p>My company has organised a lunchtime staff training session for staff. We have been sent information leaflets to read in advance of the training.</p>	<p>Learning activities</p>
<p><b>Q3 Give an example of how this learning has benefited your patients, customers or service users?</b></p> <p>This learning has benefited my service users as it helps to ensure safe and appropriate supply of medicines. If I think a customer is behaving suspiciously and / or may be requesting too much of a certain product I tell the pharmacist. The pharmacist then talks to the customer and assesses whether the supply is appropriate and/or whether the patient may have some other issue and needs to be referred. Some customers may also visit other shops in an attempt to get the product. If we have concerns regarding a particular customer we alert our other branches (we are part of a small chain). The processes we follow are documented in our standard operating procedures.</p> <p>We recently had a problem with a taxi driver who was regularly trying to buy regular supplies of Sudafed tablets. We spoke to him and then through our network discovered he was also visiting other branches in an attempt to buy the same product. We contacted the Health Board and made them aware of the situation – they then emailed all the pharmacies in the area to alert them to the situation (we were able to provide a description and car registration number). This seems to have stopped the problem.</p>	<p>How the learning has been applied</p> <p>Example of learning benefits to patients</p>

## Planned CPD – Academia

### Q1 What are you planning to learn?

I am planning to learn about the 'Prevent' organisation – it's role and functions and how it may relate to my role in teaching students.

I want to learn how to detect if a student may be radicalised, and what to do if I suspect a student is being influenced in this way.

### Q2 How are you planning to learn it?

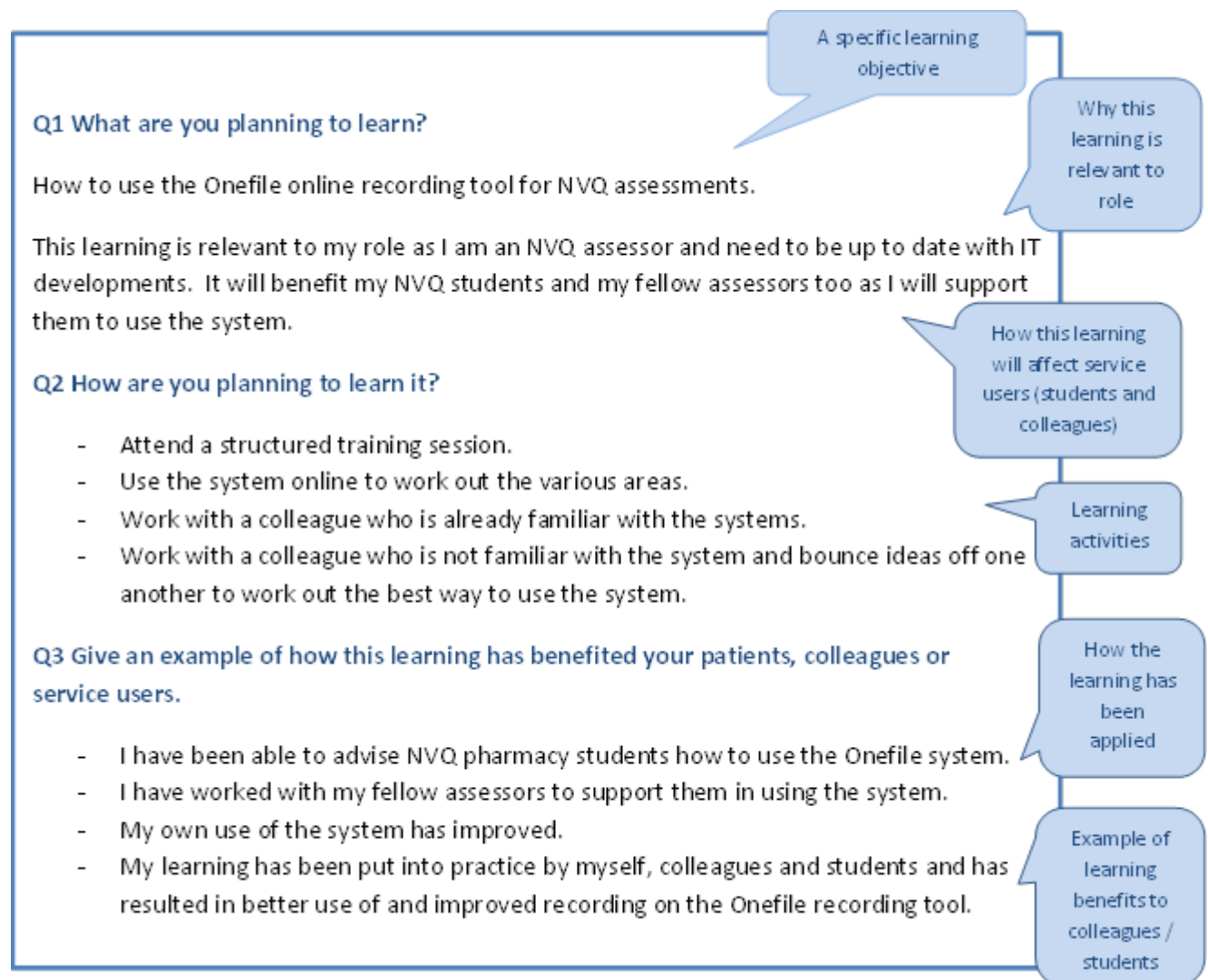
I am planning to attend a training session at the university campus in February 2016.

### Q3 Give an example of how this learning has benefited your patients, colleagues or service users.

This learning will benefit my students as I am now aware of the behaviours they may display that could indicate they are being influenced in this way. I am aware of what action to take should I have any concerns, and I would inform the relevant authorities to arrange for intervention for my student. The benefit to the student would be safeguarding, and arranging the appropriate support / intervention for them.

Colleagues in my department have benefited from my learning as I have shared my learning with them and raised awareness of the potential issues - they know that they can come to me if they have any concerns regarding any students.

## Planned CPD – NVQ Assessor



## Unplanned CPD - Hospital

<p><b>Q1 Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills</b></p> <p>I attended a recent in-house hospital clinical meeting on paediatric nutrition.</p> <p>I learnt about different milk products and allergies and when you would use regular formula, hydrolysed proteins and amino acids. I also learnt about products included in our hospital paediatric formulary and when they should be used.</p>	<p>Description of event or activity</p>
<p><b>Q2 How has this learning benefited your patients, colleagues or service users? Give an example.</b></p> <p>We sometimes receive enquiries from nursing staff and parents about paediatric nutrition. My confidence and understanding of the issues faced by parents of babies with intolerances and allergies has improved. When I receive a prescription I can now safely validate it and supply the appropriate product for the patient.</p> <p>Last week, for example, I received a prescription for a particular milk product for a 9 month baby. I checked the paediatric formulary and confirmed that the product was appropriate for the child and the dosage correct.</p> <p>I am interested in finding out more about paediatric medicines and plan to attend other clinical meetings related to paediatrics.</p>	<p>Description of what you have learnt</p> <p>How the learning has been applied</p> <p>Example of learning benefits to patients</p>
<p>Next steps</p>	

## Unplanned CPD – Community

**Q1 Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills**

Whilst conducting a medicines usage review (MUR) the patient mentioned that he had recently been experiencing an increased incidence of palpitations and missed heart beats. The patient was a 49 year old male, did not smoke, took moderate exercise and was not overweight. He said he had no previous cardiac history. I checked his blood pressure and it was within the normal range. He explained that the problem came and went but had recently got worse and thought it might be linked to stress at work.

We discussed his medication. He took amitriptyline daily for prophylactic management of migraine and cluster headaches and had recently increased the dose to manage the headaches. I recalled that amitriptyline might have cardiac side effects but wanted to check the details.

BNF: Amitriptyline [unlicensed indication] – ‘arrhythmias and heart block occasionally follow the use of tricyclic antidepressants, particularly amitriptyline, and may be a factor in the sudden death of patients with cardiac disease; other cardiovascular side effects include postural hypotension, tachycardia and ECG changes’

Online literature search:

PJ 15<sup>th</sup> October 2014. Thomson, C and Wright, P. “Long QT syndrome”

BMJ 29 Jan 2013;346:F288. Castro, VM et al. “QT interval and antidepressant use: a cross-sectional study of electronic health records”

The references confirmed that amitriptyline could cause long QT syndrome, primary symptoms may include palpitations and that symptoms were dose related. I concluded that his symptoms might be linked to either stress / dose-related side-effect of his amitriptyline, contacted the patient, informed him of my conclusions and suggested that he should be referred to his doctor for a more thorough assessment.

**Q2 How has this learning benefited your patients, colleagues or service users? Give an example.**

This CPD benefited the patient directly. He visited his GP and was referred to a cardiologist. He was found to have some abnormalities with his ECG and was diagnosed with ectopic heartbeats, which may not necessarily have been caused by the medication but could have been exacerbated. The patient is now under the care of the cardiologist and was grateful for the advice I provided.

Feedback

Description of event or activity

Description of what you have learnt

How the learning has been applied

Example of learning benefits to patient



## Unplanned CPD – Academia

<p><b>Q1 Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills</b></p> <p>I was asked to provide an internal review for the e-assessment questions linked to the new CPPE learning programme on Summary Care Records (SCR).</p> <p>Although mainly reviewing for educational robustness, I completed the associated learning programme to ensure the answers to the questions were correct and could be answered by completing the learning programme.</p> <p>This provided me with knowledge about SCR and how they can be accessed and used in community pharmacy, including what information they contain, when they can be accessed and governance requirements around their use.</p>	<p>Description of event or activity</p>
<p><b>Q2 How has this learning benefited your patients or service users? Give an example.</b></p> <p>This learning has allowed me to ensure that the learners who access this programme and the linked assessment are provided with accurate knowledge and testing so that they can be confident that they are acting within the law when accessing records in community pharmacy. Ultimately this will have a direct impact on patients who will be able to access improved care from the pharmacy when they need it.</p> <p>This learning will also benefit the users of any learning I develop in the future as I will be able to incorporate this knowledge into programmes to allow them to think how access to SCR can have a positive impact on patient care.</p>	<p>Description of what you have learnt</p> <p>How the learning has been applied</p> <p>Example of learning benefits to service users and patients</p>
<p>Next steps</p>	

**Q1 Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills**

I am a pharmacist and work for a pharmaceutical company. We have a standard operating procedure (SOP) for Product Recalls that need, in line with good working practices, to be tested on an annual basis. A recall might occur for example when a company has to remove a product because of design or production defects that may compromise safety, efficacy and purity of the product or because of government regulation. Our company performs 'mock product recalls' to check that the various steps in the SOP work and that a product can be recalled in a timely manner, fully reconciled and accounted for, should this be required. We recently instigated a mock recall that highlighted some potential business risks.

The following learning points were identified:

- When conducting a mock recall, careful consideration needs to be given to who to contact and when. In this particular study there are over 150 active sites. Our Recall Committee deliberated on who to contact and eventually decided to contact a sample of 10 sites. This decision making took valuable time and resource and delayed the notification to sites.
- Although the Packing Organisation who prepared the supplies, the Clinical Contract Research Organisation who monitor the study and the targeted sites all responded, the mock recall was a notification exercise only. No reconciliation was performed.
- The Packing Organisation provided a stock inventory, but did not perform a physical stock count. Similarly, the target sites did not do a physical count to ensure they could locate the affected kits provided on the shelves in their clinics.

From the mock we identified areas for improvement within our Product Recall SOP.

**Q2 How has this learning benefited your patients, colleagues or service users? Give an example.**

The Product Recall SOP has been updated to reflect these key learnings. We have also introduced standard letter templates into the Product Recall SOP (in line with the MHRA Guidelines). This will simplify and speed up the process of contacting the Packing Organisation who prepares the supplies, the Clinical Contract Research Organisation (CRO) who monitor the study and the clinical sites that run the study and dose the patients.

My colleagues at work have benefited because they have a better understanding of what is required of them. Patients will also benefit if a genuine product recall was ever to take place.

For future mock recalls, the recall committee will also be more specific in terms of its requirements, to ensure the information can be obtained in a more time efficient manner.

Description of event or activity

Description of what you have learnt

How the learning has been applied

Example of learning benefits to patients and colleagues

## Peer Discussion – Hospital

Give an example of how this peer discussion changed your practice for the benefit of your patients, colleagues or service users.

I chose another medicines information (MI) pharmacist as my peer because I work in a hospital MI unit and wanted feedback from someone in the same field. As part of my role I have to participate in an annual peer review process (hospital to hospital) plus a regional MI inspection conducted every three years. In preparation for the MI inspection, we have to conduct a User Survey as evidence of the level of service provided.

My peer discussion (held as part of the annual peer review process) focused mainly on my MI management role. We ran through examples of enquiries that my team has dealt with, departmental protocols and also looked at some of my personal CPD entries.

The feedback received is helping to guide and enhance my practice. It has also given me the opportunity to reflect on some areas for development. I have for example, re-visited some of our in-house procedures and tweaked them to ensure that they are all up to date and in accordance with national MI procedures.

I have also shared how I put my learning into practice with colleagues and ensured that everyone in the team is up to date. We already collate service user feedback - the evidence of an enhanced service will be provided in the form of improved quality of documented MI query answers, and improved responses from the MI Users Survey.

Description of why you chose this peer

How this peer discussion helped you reflect on your practice

Description of change to practice

Example of how change has benefited team/enquirers

## Peer Discussion – Academia

**Give an example of how this peer discussion changed your practice for the benefit of your patients, colleagues or service users.**

I chose a health psychologist / academic to be my peer. I chose this peer because I have worked with her previously and think she would make a good mentor.

My peer discussion helped me to think about how to write up research. As a result of the discussion I have written up a piece of research in a format that would be deemed suitable for publication in a peer reviewed journal. This was a new skill I was developing and therefore involved learning by doing. I used the feedback provided to identify what further learning I needed to undertake to complete the writing of this journal article and to reflect on where I had made good progress.

We developed an action plan and produced a final draft that has been published.

The outcome of my learning and this research article is that I have increased the evidence base for the rationale for a patient centred approach to consultations and how it benefits patients and patient outcomes. Publishing my research has raised awareness of the concept of patient centred consultation skills amongst peers who read the article and I will also be a role model for this concept. There will be an indirect benefit to patients too as the intent is for pharmacy professionals enhance their consultation skills.

Description of why you chose this peer

How this peer discussion helped you reflect on your practice

Description of change to practice

Example of how change has benefited pharmacy professionals/patients

## Case Study - Senior leadership role (pharmacist)

**Describe a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy professionals. Give an example of how this change benefited your patients, colleagues or service users.**

I identified an issue of increasing mental health issues within our pharmacy professional population and as a result felt that more could be done to improve communications regarding mental health and where to go for help.

I contacted the Pharmacist Support charity and attended one of their 'wellbeing' workshops to understand how we could manage the trend and provide solutions to this issue. In terms of a change to my practice, I have deployed the same training to our pre-registration pharmacists on 'wellbeing' to ensure that new registrants have the learning before they start their career.

I believe that this new approach has benefited my colleagues as they now have a better understanding of mental health issues and where to go if they need advice.

While the incidence of contacts to the occupational health service concerning mental health issues has flattened, I am not seeing a decrease yet, but will monitor in 2016 after further wellbeing workshops have been held.

A change in practise related to "Communicate effectively"

Example of how my learning has benefited colleagues

Feedback/evidence relating to beneficial impact of change

## Case Study - Senior leadership role (pharmacist)

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While the incidence of contacts to the occupational health service concerning mental health issues has flattened, I am not seeing a decrease yet, but will monitor in 2016 after further wellbeing workshops have been held.

A change in practise related to "Communicate effectively"

Example of how my learning has benefited colleagues

Feedback/evidence relating to beneficial impact of change

## Appendix 5 Phone survey and online survey question sets

### A Pharmacists and Pharmacy Technicians Script

- Please can you tell me briefly:
- What is your role?
- Where do you work?
- What was it about this Continuing Fitness to Practice pilot study that interested you and motivated you to participate?

#### Reflective Learning

GPhC hope that the new approach will encourage more reflective learning: *GPhC definition: Reflection is the critical evaluation of practice and learning to find ways to improve outcomes for service users*

1. What does the term 'reflective learning' mean to you?
2. To what extent do you feel your learning and development during this pilot period has been reflective?
3. Has this been any different to before the pilot?
4. Did you reflect on how to apply the learning?
5. Did you reflect on what further learning needs you may have?
6. What factors have helped or hindered you in your learning being as reflective as you would like it to be? e.g. distractions, environment, interaction with colleagues?

#### Peer Discussion

Pharmacy professionals are being encouraged to engage with other people in their reflection on learning and practice, the intention being to improve practice and reduce the likelihood of professional isolation. It may be that you have acted as a peer for a colleague, but for the purpose of this interview we would like to focus on your experience as a participant.

7. How easy was it for you to identify a peer who was willing to take part in a peer discussion with you?  
(*Prompt – this includes identifying a person and them agreeing to take part*)
8. Were you able to explain what was required of them in this role?
9. How did you hold the peer discussion? Face to face, phone etc.?
10. Did this method work well?
11. Were you able to have a full and open discussion?
12. Was the meeting just to cover the CFtP discussion or part of a wider meeting? e.g. a regular 1-1?
13. If part of a wider meeting, what was this, and what impact did this have?
14. What were the outcomes / benefits you hoped to achieve from a peer discussion?  
(*prompt – external view, in-depth thinking, reflection*)
15. What do you think you could get from the peer discussion that was different from other parts e.g. case studies ?  
(*prompt – external view, in-depth thinking, reflection*)
16. Were there any particular outcomes that you felt were more important to achieve than others?



17. Do you feel that all of the outcomes or benefits you hoped to get from the peer discussion were achieved? *(prompt – what helped this, what hindered, ask about the media (phone, face to face etc.)*
18. Did you feel you gained further [or new] insight to your practice as a result of the discussion? *(did you do anything differently as a result?)*
19. Did you do anything differently as a result?
20. Did you experience any unexpected outcomes?
21. Was any additional time or resource or cost required in relation to the peer discussion e.g. time prior to, or after, the peer discussion for background/ preparation?
22. In future would you be prepared to act as a peer for a colleague? What do you imagine positives and negatives of this role could be?

### Case Studies

The case study asks pilot volunteers to describe an example of a change to practice, in particular, related to communication . It provides an opportunity for pharmacy professionals to show how they are reflecting on and making changes to their practice.

23. What did you understand the purpose of the case study to be?  
*(Prompt: To describe an example of a change to practice; To describe a learning experience; To demonstrate how this learning experience affected or could in future affect the care I give to patients / service users)*
24. Do you think your case study met these purposes?  
*(Prompt – for example, have you made any changes to your practice as a result?)*
25. How did you select your case study? Were you able to reflect on what experience to use and why it was appropriate?
26. How much time did it take you to do the case study?  
*(Prompt – this would include time to identify a suitable case, think it through as well as write it up)*
27. Did you experience any problems / issues when writing up your case study?  
*(Prompt – unsure what was needed, what type of information was required, how much info/ detail, lack of time or quiet place, couldn't identify a good example)*
28. Did you make any changes to practice as a result of doing the topic/subject you used as a case study?

### Unplanned learning

The pilot asked you to record examples of unplanned learning if possible.

29. Were you able to give an example of unplanned learning?
30. How did you select your example(s) of unplanned learning?
31. What do you understand the objectives of unplanned learning to be?
32. How well do you think your example met your objectives?  
*Prompt – particularly in terms of their being reflective learning, linked to service user outcomes*
33. Did you have any particular problems or issues in reporting on these?
34. Did you find anything about the unplanned learning entry worked particularly well?
35. Did you find anything about the unplanned learning entry that didn't work well?
36. Have you made any changes to your practice as a result of any of your examples of unplanned learning?

### Planned learning

The pilot asked you to record examples of planned learning if possible



37. How many examples of planned learning were you able to identify?
38. What do you understand the objectives of planned learning examples to be?
39. How well do you think these examples met their objectives?  
*Prompt – particularly in terms of their being reflective learning, linked to patient outcomes*
40. Did you have any particular problems or issues in reporting on these?
41. Did you think anything about the planned learning went particularly well?
42. Did you find anything about the planned learning that didn't work well?
43. Have you made any changes to your practice as a result of this learning?

### Immediacy and Accessibility of Recording

**Please note that the system you used during the pilot is not the one on which the final CFtP system will be developed.**

44. Did you read the guidance provided? Did you need/ choose to refer to it more than once? >> if no, go to 50
45. Was the guidance about the CFtP pilot clear?
46. Did you make use of/ refer to the examples of good questions that were provided?
47. Was there anything in the information and examples given which could be improved? If so, how?
48. Was there any wording or terminology that you were unsure about? (*possible prompt – “case studies”*)
49. Is the number of entries appropriate?
50. Where did you usually update your CFtP record? *Prompt: home, workplace, other*
51. Was this OK - was this of choice or necessity?

### Your employer

**(Where the respondent is not self-employed)**

**This section is to understand how your employer views CFtP**

52. Is your line manager aware that you are taking part in this pilot?
53. How supportive (or otherwise) is your employer in helping you with CFtP?  
*(prompts: do you have enough time to do CFtP activities, have you got the facilities you need, are they aware you are taking part in this pilot)*
54. Do you think they see CPD or CFtP as an integral part of your role? (*has this been discussed in appraisal/ annual review*)
55. Were you able to complete CFtP activities at work in your normal working time?
56. Has the employer's attitude/ support changed with the new CFtP processes, or was this the same as in the original CPD system? In particular, were there any differences when it came to completing your peer discussion and case study entries?

### Finally.....

57. Do you feel you were able to complete this pilot process as well as you would have liked?
58. Were there any particular things which made it hard (or easy) to complete?
59. If so, did these apply to the whole process or just some parts (e.g. just peer discussions)
60. Were there consequences or aspects of completing this process which you hadn't expected?
61. Do you feel that the CFtP process is a good use of your time?

62. How does it compare with the previous CPD system in terms of helping you improve your practice and improve outcomes for patients/ service users?
63. Do you feel it is robust in providing assurance of pharmacy professionals' fitness to practice?
64. Does the time and effort it takes to complete match the benefit it gives in providing assurance?

## B Phone Interview Questions for Employers or Line Managers of Pharmacists & Pharmacy Technicians in the CFtP pilot process

1. Please tell me a bit about your organisation and what sort of work the pharmacists and pharmacy technicians employed by your organisation do?
2. What is your role in the organisation in relation to pharmacists and pharmacy technicians?
3. Roughly how many pharmacists/pharmacy technicians does your organisation employ? (bands 0-9, 10-49, 50-99, 100+)?
4. How familiar are you with the new CFtP framework?
5. What is your understanding of why the changes to pharmacists/pharmacy technicians CPD are being proposed? *(to improve reflection, practice and patient outcomes)*
6. Does your organisation offer a formal programme of learning activities for pharmacists/pharmacy technicians?
  - a. If Yes, please describe
  - b. If No, does your organisation support pharmacists/pharmacy technicians in identifying appropriate CPD opportunities?
7. Are any changes planned around these in the future?
8. Does your organisation offer any specific support to learning and development activities e.g. building protected CPD time into job plans, providing CPD activities, providing funding for CPD activities e.g. courses, etc.?
9. Are any changes planned around these in the future?
10. Is the norm in your organisation for pharmacy professionals to write up their learning and development activities in the CPD/CFtP system while at work or in their own time?
11. Are any changes planned around these in the future?
12. Are there any changes you have chosen, or needed, to make in order to support your pharmacists/ pharmacy technicians in participating in the GPhC pilot project?
13. Do you think that there are any barriers to pharmacists/pharmacy technicians employed by your organisation in fully meeting their CPD or CFtP requirements? *(in terms of both actual learning and development activities, and recording these on the system)*
14. Are there any particular groups of pharmacists or pharmacy technicians in your organisation who might find the process more difficult to complete. *(might say things like locums, part time, people not able to find time in the evenings but probably better not to prompt. Might there be any difference between CPD and CFtP for these groups)?*

15. Have you had any feedback from your pharmacists/pharmacy technicians on their experience of participating in the GPhC pilot project?
16. Have you seen any evidence of learning from CPD being applied by pharmacists/pharmacy technicians in your organisation? If so, can you give some examples?
17. Do you feel the piloted system is robust in providing assurance to you of pharmacy professional's fitness to practice?  
(Prompt – may need to explain the new system if they are not familiar with the detail)
18. Do you feel the piloted system is encouraging your employees towards more reflective practice? Is it your feeling that this is an area that needed strengthening?
19. Do you know how much time your pharmacy employees spend on their CPD activities (learning and writing up)?
20. Do you think that the time and effort it takes to complete the piloted system (CPD, peer discussion and case study) matches the benefit it gives in improving practice, improving outcomes for patients / clients and in providing assurance to the public?
21. Did you read the guidance provided to pilot participants?
22. What do you think of the guidance provided?  
(was it clear? were there any ways in which it could be improved?)
23. Have you needed to seek clarification or further information about the GPhC pilot? If so, where did you get help from and what was this in relation to (terminology, process)? Was this help available and useful?
24. As employers, what do you think the benefits may be to you of the new system?
25. What problems or issues do you think it might present?
26. Are there any changes you would like to see?
27. How could GPhC best support you if they rolled it out as is?
28. Were there any unexpected consequences of the pilot continuing fitness to practice process (negative and positive)?
29. Is there anything else you would like to tell us about?

## C Phone Interview Questions for 'Peers' in the pilot CFtP process

1. Please can you tell me briefly what is your role in your employing organisation?
2. Where do you work?
3. IF Pharmacist/Pharmacy technician: Are you participating in the CFtP pilot as a registrant?
4. How many pharmacists/pharmacy technicians have approached you to participate in a peer discussion?
5. How many peer discussions have you gone on to participate in?
6. Were you clear about what was required of you in the peer role?
7. What was your main source of information or clarification regarding your peer role?
8. What is your work relationship to the Pharmacist(s) or Pharmacy technician(s) with whom you had a peer discussion(s)?
9. How easy or difficult have you found it to make time to participate in peer discussion(s)?  
(prompt: Were there any barriers to your participation and if so what were they? Was your employer supportive regarding you carrying out the peer discussion? Was the participant's employer supportive regarding the peer discussion?)

10. Was the meeting just to cover the CFtP discussion or part of a wider meeting e.g. a regular 1-1?
11. If part of a wider meeting, what was this, and what impact did the CFtP discussion have?
12. How did you carry out your peer discussions (e.g. face to face, by phone etc.) and was it inside or outside working hours?
13. How long did the peer discussion take?
14. Did you feel this way of carrying out your peer discussion worked well and, if not, what might have worked better?
15. Were you able to have a full and open discussion?
16. Do you feel that some learning/ development needs were identified?
17. Based on your understanding, do you think that the peer discussion supported reflection on learning needs, and applying learning to changes of practice?
18. Was any additional time or resource or cost required in relation to the peer discussion e.g. time prior to, or after, the peer discussion for background/ preparation?
19. Would you be happy to continue to act as a peer for a colleague?
20. Did you gain/ learn anything in your role as peer?
21. Were there consequences or aspects of completing this process which you hadn't expected (positive and negative)?

## D Online survey question set

1. Please indicate your role.
2. Please identify the setting in which you work.
3. Which country are you located in?
4. Are you male or female
5. Do you work: full time or part time
6. If you work part time has this impacted on your ability to complete the CFtP pilot activities?
7. Are you a locum?
8. How long have you been registered to practise?
9. What is your ethnic group?
10. Is English your second language and, if so has this impacted on your ability to complete the pilot activities?
11. Do you have a disability
12. How important do you think learning and development is to your role?
13. How do you usually identify your learning and development needs? Select all that apply.
14. Have you identified any future training needs as a result of completing the CFtP pilot?
15. During the CFtP pilot, on average, how soon after completing a learning activity did you make an entry about it in the system?
16. During the CFtP pilot, did you usually record learning activities only on the CFtP system or, did you also record them separately (for example keeping your own written record which you then transcribed onto the system at a convenient time)?
17. During the CFtP pilot on how many separate occasions did you enter and / or update records

18. When you used the previous CPD system, how soon after completing a learning activity did you usually make an entry about in the system?
19. When you used the previous CPD system, did you usually record learning activities only on the CPD system or, did you also record them separately (for example keeping your own written record which you then transcribe onto the system at a convenient time)?
20. Did you upload any documents to the CFtP system?
21. If you uploaded documents to the CFtP system what were your reasons for doing this? Select all that apply.
22. Do you feel that the instructions given to you by GPhC were useful, clear and unambiguous for each of the entry types and for the overall process?
23. The term 'Reflective learning' has many potential meanings. When used by GPhC for CFtP it has been defined as 'Reflection is the critical evaluation of practise and learning to find ways to improve outcomes for patients / service users'. To what extent has your learning and development during this pilot period been reflective, using this definition from GPhC?
24. Do you feel that the CFtP system has encouraged you to engage in more reflective learning than the previous CPD system?
25. The following factors can support reflective learning. To what extent has each of these been present for you during the CFtP pilot period?
26. For each of the entries you made to the pilot system were you able to demonstrate a positive impact on the service you provide to patients / service users?
27. Over the time period of this pilot have you been able to spend as much time as you felt you needed on learning activities (for example attending conferences, reading material, completing online learning etc.)?
28. Is your employer aware that you are participating in the CFtP pilot?
29. For the process of completing your CFtP records, did your employer allow you time to complete records on the CFtP system?
30. For the overall process of participating in CFtP, did your employer allow you time to undertake learning activities?
31. Is your GPhC CPD/CFtP process linked to your work-based appraisal?
32. In principle do you think it is helpful for your GPhC CPD/CFtP process to be linked to your work-based appraisal system?
33. How easy was it for you to identify planned learning activities?
34. Approximately how long, on average, did it take you to complete each of your planned learning entries in the CFtP system (including time taken to reflect on what to include)?
35. Compared with the previous CPD system did it take more or less time to complete the planned learning entries into the CFtP system?
36. How easy was it for you to identify an opportunity for unplanned learning?
37. Approximately how long, on average, did it take you to complete each of your unplanned learning entries in the CFtP system (including time taken to reflect on what to include)?
38. Compared with the previous CPD system did it take more or less time to complete the unplanned learning entries into the CFtP system?
39. How important are the following aspects of peer discussions?

40. How easy was it for you to identify a peer who was willing to take part in a peer discussion with you?
41. Who was your peer?
42. How easy was it for you to identify a topic for your peer discussion?
43. How did you carry out your peer discussion?
44. Did your peer discussion take place during or outside working hours?
45. Did you feel that this way of carrying out your peer discussion worked well? Were you able to have a full and open discussion, with enough time?
46. Approximately how long did it take you to complete your peer discussion (including for example, time taken to identify a peer, make arrangements for the discussion, prepare for and hold the discussion and enter the write up of the discussion in the system)?
47. Within this, how long was the actual peer discussion?
48. What do you understand the purpose of the CFtP case studies to be?
49. Did you complete a case study?
50. How easy was it for you to identify an appropriate case study?
51. Of the above purposes, which did you demonstrate in the case study you completed?
52. Did you experience any problems or issues when writing up your case study?
53. Approximately how long did it take you to complete your case study entry in the CFtP system (including time taken to reflect on what to include)?
54. How much benefit do you think you get from the CFtP system in terms of improving your practise?
55. Compared to the previous CPD system, do you get more or less benefit from the CFtP system in terms of improving your practise?
56. How much benefit do you think you get from the CFtP system in terms of improving outcomes for patients / service users?
57. Compared to the previous CPD system, do you get more or less benefit from the CFtP system in terms of improving outcomes for patients / service users?
58. How much benefit do you think each component of CFtP is to your own overall continuing professional development?
59. Did you find any unexpected benefits to using the CFtP system?
60. Did you find any unexpected barriers or problems when using the CFtP system (other than technical issues such as software versions, firewalls etc.)?
61. Do you feel that the CFtP process is robust in providing evidence of your continuing fitness to practise?
62. Do you feel that the CFtP process is proportionate, in that time and effort needed to complete it is appropriate relative to its function in providing assurance of a pharmacy professional's continuing fitness to practise?
63. Do you feel that there are any ways in which the system could be improved, to make it of more value to you and patients / service users?



## Appendix 6 Analysis of online survey results by characteristic

This analysis aims to help assess whether the CFtP framework is equally accessible and useful to all. A number of questions asked in the online survey were analysed by such characteristics, to test for this. As the survey was anonymous, participants were asked, but not obliged, to state the following to allow this analysis (Questions 1 to 11):

- Their role - pharmacist or pharmacy technician
- Setting(s) - academic / educational, advisory / regulatory, hospice care, hospital, primary care / GP practice, independent community pharmacy, multiple community pharmacy, industry / science, military, secure (prison / mental health)
- Country – England, Scotland, Wales
- Gender
- Working pattern – full time, part time
- Whether they are a locum
- Number of years registered – less than 5, 5 to 10, more than 10
- Ethnic group
- Whether English is their second language
- Whether they have a disability

Two particular aspects were asked about directly. Firstly, respondents were asked if they worked full or part time (Question 5). 173, or 28.9% of those who answered this question said that they worked part time. These were asked whether working part time had impacted on their ability to complete the CFtP activities (Question 6). 39 individuals, responded that it had. This represents 6.5% of the 602 people who completed the survey, and 22.5% of those who stated that they worked part time. Secondly, respondents were asked whether, if English was their second language, this had impacted on their ability to complete pilot activities. 10 individuals answered “Yes” to this, which is 1.6% of the 602 people completing the survey.

Analyses by each of the following characteristics were carried out, and those considered to be of interest are presented here.

- Their role - pharmacist or pharmacy technician
- Setting(s) - academic / educational, advisory / regulatory, hospice care, hospital, primary care / GP practice, independent community pharmacy, multiple community pharmacy, industry / science, military, secure (prison / mental health)
- Country – England, Scotland, Wales
- Gender
- Working pattern – full time, part time
- Whether they are a locum
- Number of years registered – less than 5, 5 to 10, more than 10
- Ethnic group
- Whether they have a disability

The analyses were applied to a range of survey questions, selected to represent the key themes addressed throughout this evaluation. These questions were:

- Were the instructions given for the overall process of the pilot clear and unambiguous? (Question 22)

- Did you have enough time without distractions to think through what your learning and development needs were? (Question 22)
- For the process of completing your CFtP records, did your employer allow you time to complete records on the CFtP system? (Question 29)
- How soon after completing a learning activity did you make an entry about it in the system? (Question 15)
- Approximately how long, on average, did it take you to complete each of your planned learning entries (including time taken to reflect on what to include)? (Question 34)
- Approximately how long, on average, did it take you to complete each of your unplanned learning entries (including time taken to reflect on what to include)? (Question 37)
- Approximately how long did it take you to complete your peer discussion (including for example time taken to identify a peer, make arrangements for the discussion, prepare for and hold the discussion)? (Question 46)
- Did you complete a case study? (Question 47)
- Approximately how long did it take you to complete your case study entry in the CFtP system (including time taken to reflect on what to include)? (Question 53)
- To what extent has your learning and development during the trial period been reflective? (Question 23)
- For each of the entries you made to the pilot system, were you able to demonstrate a positive impact on the service you provide to patients/service users? (Question 26)
- Do you feel that the CFtP system is robust in providing evidence of your fitness to practice? (Question 54)

As described in the main body of the report, analyses of these responses was carried out by comparing the percentages of responses in each possible answer across each grouping within a category, as shown in Table 22 below. This was done manually by visual checking, as the range of response types varied, making tests of statistical significance less practicable. The small numbers shown in a number of groupings also made these less reliable and useful.

With the exception of ethnicity, where the individual had not stated which category they belonged to, their responses were not included in the analysis. Similarly, respondents not answering the question were excluded from that analysis.



**Table 22: Example of analyses of question responses by characteristic**

<b>To what extent has your learning and development during this pilot period been reflective?</b>				
Question 23				
<b>Number of responses</b>				
<b>Role</b>	<b>Pharmacist</b>	<b>Pharmacy Technician</b>	<b>Not stated</b>	<b>Total</b>
Fully	71	6		<b>77</b>
To a large extent	326	58	2	<b>386</b>
To a small extent	72	19	1	<b>92</b>
It hasn't been reflective based on this definition	6	2		<b>8</b>
Don't know	3	2		<b>5</b>
No response given	23	11		<b>34</b>
<i>Total</i>	<i>501</i>	<i>98</i>	<i>3</i>	<i><b>602</b></i>
<b>Total of all responses given</b>	<b>478</b>	<b>87</b>	<b>3</b>	<b>568</b>
<b>Percentage of responses</b>				
<b>Role</b>	<b>Pharmacist</b>	<b>Pharmacy Technician</b>	<b>Not stated</b>	<b>total</b>
Fully	15%	7%	0%	<b>14%</b>
To a large extent	68%	67%	67%	<b>68%</b>
To a small extent	15%	22%	33%	<b>16%</b>
It hasn't been reflective based on this definition	1%	2%	0%	<b>1%</b>
Don't know	1%	2%	0%	<b>1%</b>
No response given	5%	13%	0%	<b>6%</b>
<i>Total</i>	<i>105%</i>	<i>113%</i>	<i>100%</i>	<i><b>106%</b></i>
<b>Total of all responses given</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: SPH Online survey

It should be noted that all individual pharmacy professionals will have been categorised into the characteristic groupings given, and that these have been analysed separately, so for example, a particular pharmacy technician may also have their results shown as a community pharmacist, as a person working full time, of Indian ethnic grouping etc.

Review of all these questions showed that overall, no individual grouping was consistently advantaged or disadvantaged. Some variations in responses to particular questions were noted, and these are explored here. Variations most commonly occurred between settings, which may be as a result of the large number of settings and hence smaller numbers of individuals in each. These results should be treated as indicative, particularly where there are small numbers in any one grouping, and an issue to consider for further investigation as the GPhC moves forward.

- Were the instructions given for the overall process of the pilot clear and unambiguous? (Question 22)

Differences were apparent between different settings, as shown in Table 23 below.

**Table 23: Percentages of responses by setting, Question 22**

Were the instructions for the overall process of CFtP clear and unambiguous?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than one setting	Multiple community pharmacy	Other	Primary care / GP practice
Yes, very clear	23%	18%	31%	30%	38%	37%	20%	34%
Yes, quite clear	62%	61%	46%	53%	49%	45%	60%	39%
No, I had some queries	10%	18%	19%	16%	14%	15%	0%	20%
No, it was unclear	3%	4%	3%	2%	0%	3%	20%	4%
I did not use them	3%	0%	1%	0%	0%	1%	0%	4%
Number of respondents	39	28	121	57	80	137	15	80

Source: SPH online survey

Other differences were seen between country, with 17% of respondents from England saying that they had some queries, against 14% from Scotland and 8% from Wales. Similarly, looking by working pattern, 13% of full time respondents reported having some queries against 22% of part time respondents.

- Did you have enough time without distractions to think through what your learning and development needs were? (Question 22)

Approximately equal percentages of pharmacists and pharmacy technicians agreed that they had enough time, but 16% of pharmacists and 9% of pharmacy technicians reported that they strongly agreed.

Responses by setting were again mixed, and are shown in Table 24 below.

**Table 24: Percentages of responses by setting, Question 22**

I have had enough time without distractions to think through what my learning and development needs are								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than one setting	Multiple community pharmacy	Other	Primary care / GP practice
Strongly agree	15%	22%	6%	14%	23%	18%	7%	13%
Agree	60%	44%	55%	66%	57%	64%	57%	60%
Disagree	20%	26%	31%	14%	15%	12%	21%	13%
Strongly disagree	3%	4%	5%	7%	4%	5%	14%	10%
Don't know	3%	4%	3%	0%	1%	1%	0%	5%
Number of respondents	40	27	121	58	81	140	14	80

Source: SPH online survey

32% of respondents from Wales disagreed or strongly disagreed with the statement, against 24% from England and 21% from Scotland.

14% of locums disagreed or strongly disagreed with the statements, against 25% of non-locums

- For the process of completing your CFtP records, did your employer allow you time to complete records on the CFtP system? (Question 29)

There was some variability in responses to this by setting, with the percentages responding “No” being:

Academic/Education – 43%

Advisory/Regulatory – 39%

Hospital – 55%

Independent Community Pharmacy – 49%

More than one setting – 45%  
 Multiple Community Pharmacy – 56%  
 Other – 27%  
 Primary Care/GP Practice – 53%

Looking at gender, 54% of females against 43% of males replied “No”.

49% of full time respondents replied “No” against 58% of part time respondents.

- How soon after completing a learning activity did you make an entry about it in the system? (Question 15)

Variability by setting was shown in responses to this question, as shown in Table 25 below.

**Table 25: Percentages of responses by setting, Question 15**

How soon after completing a learning activity did you make an entry about it in the system?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than one setting	Multiple community pharmacy	Other	Primary care / GP practice
Within a day	3%	4%	2%	12%	0%	4%	0%	0%
More than a day and less than a week	8%	7%	7%	14%	22%	13%	0%	0%
More than a week and less than 3 months	58%	61%	56%	50%	52%	55%	60%	52%
More than 3 months	15%	14%	16%	9%	10%	15%	0%	15%
I haven't yet completed all entries	18%	14%	19%	16%	16%	13%	33%	15%
<i>Number of respondents</i>	42	29	129	60	85	153	17	83

Source: SPH online survey

For locums, 27% had completed their entries in under a week, whereas for non-locums this figure was 15%.

Length of time registered also showed some variability, as shown in Table 26 below.

**Table 26: Percentages of responses by number of years the participant has been registered, Question 15**

How soon after completing a learning activity did you make an entry about it in the system?			
	Less than 5 years	Between 5 and 10 years	More than 10 years
Within a day	6%	3%	3%
More than a day and less than a week	28%	13%	11%
More than a week and less than 3 months	40%	52%	57%
More than 3 months	8%	15%	14%
I haven't yet completed all entries	18%	18%	15%
<i>Number of respondents</i>	50	108	414

Source: SPH online survey

Differences by ethnic group were also apparent, particularly in the percentages completing their entries within a day of the learning activity, which was 11% (84) for ‘others’, 2% (437) for British, 5% (42) for Indian and 0% (84) where the ethnic group was not stated.

- Approximately how long, on average, did it take you to complete each of your planned learning entries (including time taken to reflect on what to include)? (Question 34)

Responses to this question were broadly similar across groupings. Some differences were seen by setting, as shown in Table 27 below.

**Table 27: Percentages of responses by setting, Question 34**

Approximately how long, on average, did it take you to complete each of your planned learning entries (including time taken to reflect on what to include)?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than one setting	Multiple community pharmacy	Other	Primary care / GP practice
Less than 30 minutes	26%	50%	25%	21%	33%	17%	29%	24%
Between 30 minutes and 1 hour	51%	35%	47%	33%	39%	49%	29%	43%
Between 1 hour and 1.5 hours	18%	15%	18%	26%	14%	25%	21%	15%
Between 1.5 and 2 hours	3%	0%	5%	7%	3%	6%	21%	9%
Over 2 hours	3%	0%	4%	14%	11%	2%	0%	9%
Number of respondents	39	26	118	58	79	140	14	79

Source: SPH online survey

When looking by ethnic group, 72% (of 424) of British respondents had completed their planned learning entries in less than an hour. This figure was 52% (of 42) for Indian respondents, 55% (of 11) for those whose ethnicity was not stated and 55% (of 72) for those in 'Other' ethnic groups.

- Approximately how long, on average, did it take you to complete each of your unplanned learning entries (including time taken to reflect on what to include)? (Question 37)

When looking at the time taken to complete unplanned entries, variability was again shown by setting, as shown in Table 28 below.

**Table 28: Percentages of responses by setting, Question 37**

Approximately how long, on average, did it take you to complete each of your unplanned learning entries in the CFtP system (including time taken to reflect on what to include)?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than one setting	Multiple community pharmacy	Other	Primary care / GP practice
Less than 30 minutes	33%	56%	34%	26%	38%	26%	29%	35%
Between 30 minutes and 1 hour	50%	40%	46%	38%	37%	51%	50%	40%
Between 1 hour and 1.5 hours	14%	4%	18%	16%	14%	15%	7%	12%
Between 1.5 and 2 hours	0%	0%	2%	7%	5%	7%	14%	9%
Over 2 hours	3%	0%	1%	14%	5%	1%	0%	5%
Number of respondents	36	25	114	58	78	136	14	78

Source: SPH online survey

11% (of 47) locums completed their entries in over 2 hours, against 3% (of 493) non locums.

When looking by ethnic group, 80% (of 463) of British respondents had completed their unplanned learning entries in less than an hour. This figure was 66% (of 40) for Indian respondents, 55% (of 9) for those whose ethnicity was not stated and 69% (of 80) for those in 'Other' ethnic groups.

- Approximately how long did it take you to complete your peer discussion (including for example time taken to identify a peer, make arrangements for the discussion, prepare for and hold the discussion)? (Question 46)

A greater degree of variability was found between groups when completing their peer discussions than was the case for planned and unplanned entries. This may reflect differences in familiarity with this way of working between different groups. Another possible reason is that different groups find the process of arranging the discussions more or less time consuming than others. For a number of pharmacy professionals the whole peer discussion process took a significant amount of time, in some cases over 15 hours. This is a

significant impact and likely to act as a barrier to participation. A detailed picture is therefore presented here, to allow the GPhC to identify particular groups they may need to target specific communication towards, both for participants and peers, or other support such as training, to help manage the time taken by peer discussions.

**Table 29: Percentages of responses by role, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>		
	Pharmacist	Pharmacy Technician
Less than 2 hours	33%	47%
Between 2 and 5 hours	46%	40%
Between 6 and 8 hours	12%	4%
Between 9 and 11 hours	3%	1%
Between 12 and 15 hours	1%	0%
Over 15 hours	3%	3%
Don't know	3%	5%
<i>Number of respondents</i>	<i>430</i>	<i>78</i>

Source: SPH online survey

**Table 30: Percentages of responses by setting, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than 1 setting	Multiple community pharmacy	Other	Primary care / GP practice
Less than 2 hours	32%	33%	44%	27%	38%	32%	31%	36%
Between 2 and 5 hours	57%	46%	44%	46%	36%	49%	8%	48%
Between 6 and 8 hours	8%	8%	6%	15%	17%	9%	31%	11%
Between 9 and 11 hours	3%	0%	5%	4%	1%	2%	8%	0%
Between 12 and 15 hours	0%	0%	0%	2%	1%	0%	8%	1%
Over 15 hours	0%	8%	1%	2%	6%	3%	0%	3%
Don't know	0%	4%	1%	4%	1%	5%	15%	1%
<i>Number of respondents</i>	<i>37</i>	<i>24</i>	<i>108</i>	<i>52</i>	<i>72</i>	<i>128</i>	<i>13</i>	<i>73</i>

Source: SPH online survey

**Table 31: Percentages of responses by gender, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>		
	Female	Male
Less than 2 hours	30%	46%
Between 2 and 5 hours	51%	33%
Between 6 and 8 hours	11%	11%
Between 9 and 11 hours	2%	3%
Between 12 and 15 hours	1%	1%
Over 15 hours	2%	4%
Don't know	3%	2%
<i>Number of respondents</i>	352	155

Source: SPH online survey

**Table 32: Percentages of responses by working pattern, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>		
	Full time	Part time
Less than 2 hours	38%	29%
Between 2 and 5 hours	44%	48%
Between 6 and 8 hours	10%	12%
Between 9 and 11 hours	3%	2%
Between 12 and 15 hours	1%	1%
Over 15 hours	3%	3%
Don't know	3%	4%
<i>Number of respondents</i>	352	155

Source: SPH online survey

**Table 33: Percentages of responses by locum/not locum, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>		
	Not locum	Locum
Less than 2 hours	35%	33%
Between 2 and 5 hours	47%	26%
Between 6 and 8 hours	9%	26%
Between 9 and 11 hours	2%	7%
Between 12 and 15 hours	1%	0%
Over 15 hours	3%	5%
Don't know	3%	5%
<i>Number of respondents</i>	465	43

Source: SPH online survey

**Table 34: Percentages of responses by number of years registered, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>			
	Less than 5 years	Between 5 and 10 years	More than 10 years
Less than 2 hours	38%	42%	33%
Between 2 and 5 hours	24%	40%	49%
Between 6 and 8 hours	20%	8%	10%
Between 9 and 11 hours	4%	1%	2%
Between 12 and 15 hours	0%	1%	1%
Over 15 hours	4%	3%	2%
Don't know	9%	5%	2%
<i>Number of respondents</i>	45	93	370

Source: SPH online survey

**Table 35: Percentages of responses by ethnic group, Question 46**

<b>Approximately how long did it take you to complete your peer discussion?</b>				
	Indian	British	Not stated	Other
Less than 2 hours	44%	36%	18%	32%
Between 2 and 5 hours	41%	47%	45%	39%
Between 6 and 8 hours	3%	10%	18%	15%
Between 9 and 11 hours	3%	2%	9%	1%
Between 12 and 15 hours	3%	0%	0%	3%
Over 15 hours	3%	2%	9%	7%
Don't know	5%	3%	0%	3%
<i>Number of respondents</i>	39	388	11	72

Source: SPH online survey

Did you complete a case study? (Question 47):

- 74% of pharmacy technician respondents completed a case study, compared with 81% of pharmacists.

The percentages completing a case study by setting were:

- Academic/Education – 89%
- Advisory/Regulatory – 81%
- Hospital – 81%
- Independent Community Pharmacy – 74%
- More than one setting – 76%
- Multiple Community Pharmacy – 80%
- Other – 79%
- Primary Care/GP Practice – 82%

82% of females and 75% of males completed case studies.

71% of those who have been registered for under 5 years completed a case study. The percentage for those who have been registered for 5 to 10 years was 74%, and for those who have been registered for more than 10 years, 83%.

Differences were also found by ethnic group. Of those who identified themselves as British, 81% completed a case study. The figures for those identifying themselves as Indian, 'Other' ethnic groups or not stating their ethnic group were 69%, 83% and 82% respectively.

- Approximately how long did it take you to complete your case study entry in the CFtP system (including time taken to reflect on what to include)? (Question 53)

Responses to this question also varied to a greater degree than for planned and unplanned entries, although more consistency was seen than was the case for peer discussions.

Differences of note were that 37% of pharmacists completed their case study entries in less than one hour, against a percentage of 51% for pharmacy technicians.

Differences by setting are shown in Table 36 below.

**Table 36: Percentages of responses by setting, Question 53**

Approximately how long did it take you to complete your case study entry?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than 1 setting	Multiple community pharmacy	Other	Primary care / GP practice
Less than 30 minutes	6%	10%	5%	5%	10%	6%	9%	4%
Between 30 minutes and 1 hour	33%	43%	32%	18%	31%	38%	0%	22%
Between 1 and 1.5 hours	39%	24%	32%	33%	23%	21%	18%	22%
Between 1.5 and 2 hours	9%	10%	16%	15%	13%	16%	9%	12%
Between 2 and 3 hours	3%	0%	7%	18%	13%	7%	45%	5%
Over 3 hours	9%	10%	9%	13%	8%	6%	18%	6%
Don't know	0%	5%	0%	0%	2%	5%	0%	0%
Number of respondents	33	21	92	40	61	108	11	92

Source: SPH online survey

Looking at results by gender, 10% of males completed their case study entries in less than 30 minutes, compared with 5% of females. However, 17% of males completed their case studies in 2-3 hours, compared with 5% of women.

21% of locums took less than 30 minutes, against 6% of non-locums.

- To what extent has your learning and development during the trial period been reflective? (Question 23)

There were notable differences between groups within a number of characteristics. This may be due to having less time and/or opportunity for reflection. As reflective learning is a key underpinning to the CFtP system, the GPhC may wish to look into this issue in more depth, to be able to offer appropriate support if needed.

15% of pharmacists and 7% of pharmacy technicians reported that their learning and development had been fully reflective. 68% and 67% respectively reported that it had been reflective to a large extent, and 15% and 22% respectively reported that it had been reflective to a small extent.

Results by setting are shown in Table 37 below.



**Table 37: Percentages of responses by setting, Question 23**

To what extent has your learning and development during this pilot period been reflective?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than 1 setting	Multiple community pharmacy	Other	Primary care / GP practice
Fully	15%	22%	14%	22%	11%	7%	14%	17%
To a large extent	65%	63%	62%	60%	80%	73%	50%	65%
To a small extent	18%	15%	20%	14%	9%	18%	29%	16%
It hasn't been reflective based on this definition	3%	0%	2%	2%	0%	1%	7%	1%
Don't know	0%	0%	2%	2%	0%	1%	0%	0%
Number of respondents	40	27	122	58	81	142	14	81

Source: SPH online survey

When looking at responses by the number of years registered, 27% of those registered for less than 5 years reported that their learning had been fully reflective, compared with 11% for those registered between 5 and 10 years, and 13% for those registered more than 10 years.

There were also differences by ethnic group, with 12% of British respondents saying that their learning had been fully reflective, against 21% for Indian respondents, 8% where ethnicity was not stated, and 21% where the ethnic group was 'Other'.

- For each of the entries you made to the pilot system, were you able to demonstrate a positive impact on the service you provide to patients/service users? (Question 26)

While similar proportions of pharmacists and pharmacy technicians reported demonstrating a positive impact for all their entries, for 'Yes, in most entries' the percentages were 44% and 34% respectively, and for 'Yes, in some entries', the percentages were 12% and 20% respectively.

Differences were also seen by setting, as shown in Table 38 below.

**Table 38: Percentages of responses by setting, Question 26**

For each of the entries you made to the pilot system were you able to demonstrate a positive impact on the service you provide to patients / service users?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than one setting	Multiple community pharmacy	Other	Primary care / GP practice
Yes, in all entries	35%	52%	36%	36%	42%	44%	36%	51%
Yes, in most entries	45%	44%	46%	48%	48%	39%	36%	30%
Yes, in some entries	20%	4%	12%	16%	10%	16%	14%	12%
No, not for any entries	0%	0%	2%	0%	0%	1%	14%	2%
Don't know	0%	0%	3%	0%	0%	1%	0%	5%
Number of respondents	40	27	122	58	81	142	14	81

Source: SPH online survey

Differences were also seen when looking at the number of years respondents had been registered. 31% of those who have been registered less than 5 years reported that they had demonstrated an impact in all their entries, compared with 42% of those registered between 5 and 10 years, and 43% for those registered more than 10 years.

For the response 'Yes, in most entries', the percentages were 50%, 39% and 42% respectively, and for 'Yes, in some entries', 10%, 17% and 13%.

- Do you feel that the CFtP system is robust in providing evidence of your fitness to practice? (Question 54)

All groups were quite consistent in their responses to this question, although there were some differences between settings, as shown in Table 39 below, which the GPhC may wish to investigate further.

**Table 39: Percentages of responses by setting, Question 26**

Do you feel that the CFtP process is robust in providing evidence of your continuing fitness to practise?								
	Academic / educational	Advisory / regulatory	Hospital	Independent community pharmacy	More than 1 setting	Multiple community pharmacy	Other	Primary care / GP practice
Yes, very robust	8%	9%	2%	0%	1%	0%	8%	4%
Yes, quite robust	55%	61%	60%	57%	49%	54%	46%	56%
No, not very robust	16%	13%	19%	31%	25%	32%	8%	25%
No, not at all robust	11%	13%	12%	6%	19%	9%	23%	11%
Don't know	11%	4%	7%	6%	5%	5%	15%	4%
<i>Number of respondents</i>	38	23	115	54	79	133	13	75

Source: SPH online survey

## Appendix 7 Examples of Planned Learning Entries

### Example 1

Q4. What are you planning to learn?

My employer has asked me to provide Emergency Contraception service under NHS PGD. For this service I would like to gain more knowledge about the service and complete the Declaration of Competence (DoC) process on CPPE website. This learning is vital to provide a successful EHC service under PGD. Pharmacies are ideal place to supply EHC at times when the GP surgery may be too busy or during out of hours. By getting accredited to provide EHC under NHS PGD, I would be able to help the users of my pharmacy when they require EHC.

Q5. How are you planning to learn it?

I am going to complete CPPE course on Emergency Contraception and Safeguarding children and vulnerable adults and undertake e-assessment for each course. I will also read and understand PGD document available to familiarise myself with inclusion and exclusion criteria. I will read the product literature of each product to be supplied under the PGD.

Q6. Give an example of how this learning benefited your patients or service users.

After completing CPPE courses on Emergency Contraception and Safeguarding children and vulnerable adults, I have completed the Declaration of Competence on CPPE website. I am confident about providing emergency contraception service in my pharmacy safely and effectively. I have supplied EHC under NHS PGD to one of our regular patients. The patient required EHC on Saturday morning and the GP surgery was closed. The patient did not want to go to a walk in centre due to a long wait to see a doctor. Therefore she came to the pharmacy for EHC under the PGD service. As I have completed the accreditation process, I was able to provide the service as per PGD requirements. The patient was happy with the service as it saved her time from a long wait at the walk in centre.

### Example 2

Q4. What are you planning to learn?

I am planning to learn about the cost effective prescribing of long-acting muscarinic antagonists (LAMA's) in COPD. My aim is to assess patients for suitability to switch from Tiotropium (Spiriva) inhalers to Incruse Ellipta (umeclidinium) or, for those patients also on a prescribed LABA, Anoro Ellipta (umeclidinium & vilanterol). This learning is relevant to my role as a pharmacy support facilitator. I have to be able to effectively, without compromising patient safety or care switch patients from Tiotropium Inhalers to Incruse Ellipta or Anoro Ellipta inhalers. I have been asked to perform this switch in various GP Practices. This learning will mean:

- patients will have their medication reviewed by someone who understands and is knowledgeable about their illness and medication requirements
- patients will get the opportunity to be counselled on the most appropriate inhaler for them and the correct use of it
- by switching patients to the preferred meter I will be able to save X (health board) a considerable amount of money
- The GP practices have their patients medication reviewed with minimum input from the practice staff

Q5. How are you planning to learn it?

I plan to read through the SOP and support pack provided. This will inform me why we are making the change and how to complete the objectives. I plan to read the Review guide on

the Cost-effective prescribing of long-acting muscarinic antagonists (LAMA's) in COPD I have been supplied with. I also plan to talk to experienced colleagues and meet with the GP practice nurses who are involved with the COPD patients to explain the review and ask for any input or experience they may be able to share.

Q6. Give an example of how this learning benefited your patients or service users.

I have applied the learning by reviewing patients notes and switching only the appropriate patients to the new inhalers. Patients not switched were e.g. patients with a current exacerbation (to be reviewed at a later date), patients with asthma only, or patients where their life circumstances made the switch inappropriate. Learning benefits for patients is that they are given the opportunity to be counselled and trained on their new inhalers. The patient can speak to someone over the phone or face to face who understands their problem and has a good basic knowledge of their treatment. Patients have said the new inhaler is easier to use.

## Appendix 8 Examples of Unplanned Learning Entries

### Example 1

Q8. Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills.

As I work in community pharmacy, I received a letter addressed to the Pharmacist. The letter was from XX. The letter was highlighting the new safety information relating to the canagliflozin-containing medicines Invokana and Vokanamet. This immediately caught my attention as one of the GP's in the practice next door had phoned the previous week, as he was thinking of commencing a patient on it and he wanted to check its availability.

The letter highlighted a two-fold higher incidence of lower limb amputation (primarily the toe) has been seen in a clinical trial with canagliflozin. The issue is currently under investigation. Dehydration and volume depletion may play a role in the development. Having read this I decided to look up canagliflozin in the BNF as I have not seen it in practice: NICE guidance - Canagliflozin in combination therapy for treating type 2 diabetes (June 2014).

Canagliflozin in a dual therapy regimen in combination with metformin is recommended for the treatment of type 2 diabetes, only if a sulfonylurea is contra-indicated or not tolerated or the patient has a significant risk of hypoglycaemia. Canagliflozin in a triple therapy regimen is an option for the treatment of type 2 diabetes in combination with metformin and a sulfonylurea or metformin and a thiazolidinedione. Canagliflozin in combination with insulin (alone or with other antidiabetic drugs) is an option for the treatment of type 2 diabetes. Patients currently receiving canagliflozin in a dual or triple therapy regimen that is not recommended according to the above criteria should have the option to continue treatment until they and their clinician consider it appropriate to stop ([www.nice.org.uk/TA315](http://www.nice.org.uk/TA315)).

The Scottish Medicines Consortium has advised (May 2014) that canagliflozin (Invokana®) is accepted for restricted use within NHS Scotland for the treatment of type 2 diabetes in combination with metformin as dual therapy, or in combination with metformin and standard of care as triple therapy, or in combination with insulin and standard of care. Standard of care refers to any antidiabetic drugs that are indicated to be prescribed in combination with metformin or insulin for the treatment of type 2 diabetes.

Q9. Give an example of how this learning benefited your patients or service users.

This learning benefited my patients as I am now more informed about the drug canagliflozin. I decided to phone the GP that had queried the availability of canagliflozin and highlight this new alert that had come through regarding higher incidence of limb-amputation. He was extremely thankful for the phone call as he was closely monitoring this patient and as the patient was suffering from neuropathy he felt it was best to continue with current therapy. I felt that my learning not only improved my knowledge base but also supported another healthcare professional.

### Example 2

Q8. Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills.

Whilst on my clinical area, I came across a drug on a patient's medication chart, that I was unfamiliar with. The drug was Entresto. Prior to ordering the drug for this patient, I advised the ward Pharmacist that we did not stock this drug, and I would enquire how long it would take us to get this drug in for the patient. I learnt this drug was for the treatment of Heart

Failure, the drug was available in three different strengths, I learnt the dosing regimens for this drug and also the vast amount of contra-indications that go with this drug. It was important that the patient received this drug as soon as we could possibly get it from the wholesalers.

Q9. Give an example of how this learning benefited your patients or service users.

This learning alerted me to a new drug which had been prescribed within my own clinical area, the importance in the patient in receiving their medicines at the appropriate time, with minimum delay. It was stocked at our wholesalers so were able to obtain this medication on next day delivery. After discussions with the Cardiology pharmacist and the Senior Charge Nurse we decided to add one box of each strength of Entresto to the ward stock list, this will stop delay for future patients if they are prescribed this drug. I also met with the other clinical pharmacy technicians within my team and I delivered a mini training session on this drug and advised it had now been added to the ward stock lists. So overall this was very beneficial to the service user and the clinical pharmacy technicians working in Cardiology.

## Appendix 9 Examples of Peer Discussion Entries

### Example 1

Q12. Describe how has this peer discussion changed your practice for the benefit of your patients or service users.

I decided to have peer discussion with my line manager regarding the pharmacy services provided to an off-site elderly care ward. I chose my line manager because of her experience at the Trust, understanding of clinical pharmacy on the wards and her awareness of the challenges of working on an off-site ward. My line manager would be able to provide useful guidance and advice.

My peer discussion focused on how pharmacy services to the off-site elderly ward could be improved. This involved reviewing current practice and how changes could be made to improve quality, efficiency and safety. I was also able to reflect on what had been tried before and what went well and what went not as well including feedback from the ward Medicines Management Technician, Assistant Technical Officer and nursing staff.

I found the discussion very insightful and have used it to guide changes to my own practice and review areas for further learning and development. For example, communication and handover to fellow pharmacy colleagues was identified as an issue and I now ensure that a clear handover of patients is left in the pharmacy handover folder on the ward. It provides a useful method to communicate with each other as we don't visit the ward at the same time but if something needs to be completed or followed up, this is all communicated via this method.

I have shared my learning with other members of the team who work on the off-site ward so that they are aware of the changes made and I have also highlighted the need for continual review and feedback.

I have received good feedback from the nursing staff especially with regards to better stock management so patients have access to medicines in a timely manner. As a result of the peer discussion and speaking to the ward consultant I have decided to enrol on a non-medical prescribing course.

### Example 2

Q12. Describe how has this peer discussion changed your practice for the benefit of your patients or service users.

I chose to have a peer discussion with X as we have both headed up 'Teach and Treat' programmes for independent prescriber pharmacists within our health board. I wanted to reflect on what has worked well and what hasn't worked so well with my own cohort and also gain from the learning and experience from X's cohort.

We focused on the outcomes from our services and how we could improve the programmes next time around. I detailed the feedback from the pharmacists that had completed my training programme and discussed some of the problems I had encountered and how these could be overcome. We also reflected on how we have worked together over the past 6 months and how we both adapted our approach to meet the needs of the other.

The discussion has shown me the value of understanding a colleague's working style and adapting my ways of working to achieve the best outcomes when working together and I will make this an integral part of my groundwork when starting out on a project with a colleague. I have already put this into practice for a piece of work on continence I have commenced

with a nurse colleague and from the outset we are making fast progress. I have used the reflections from the discussion to inform the design of the next 'Teach and Treat' programme to make it more person-specific and avoid wasted time for participants going over areas where they are already competent and confident, so making the programme more valuable to them.

### Example 3

Q12. Describe how has this peer discussion changed your practice for the benefit of your patients or service users.

I chose another pharmacist store manager to be my peer as I have a good relationship with her and she has more experience in the role. My peer discussion helped me think about prioritising my workload, in order that I am in a good position to support patients' with services. I was feeling that I did not have time to complete asthma LES reviews and CMS interventions with patients that I felt would have benefitted from these services. This was partly due to the manager workload I was juggling and it was taking away from spending quality time with my patients.

As a result of the discussion, I now know how another store manager prioritises workload. X sets aside specific time periods where she will focus on her managerial tasks every day. As she knows her business well, she knows when is appropriate to carry out her managerial tasks in order that her patients do not suffer. In addition, she has coached her team to adopt the healthcare people model, advocated by X (Pharmacy company), in order that her team support her and she is free to speak with her patients.

This made me reflect on my own working environment and I realised that I was perhaps doing too many things myself and not coaching and then worrying about when I would do all the tasks rather than planning in the time. Having identified a need to change to benefit my patients, I have since set aside a time frame where I look at managerial related jobs. I am also now coaching my healthcare assistant with her dispenser training and have support from my registered technician.

The aforementioned will most definitely have a direct benefit to my patients as I will be more available and my team will be trained to a higher level. Already, I have had time to talk to one of my patients about his inhaler technique through the new asthma LES and have documented several CMS new medication interventions.



## Appendix 10 Examples of Case Study Entries

### Example 1

Q13. Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals that has benefited your patients or service users.

I currently run a clinic in pain management as an Independent prescriber and attended a training event where one of the speakers was from the patient alliance and as part of his short presentation on behalf of patients, he discussed using the Teach Back technique as a method of ensuring that practitioners are communicating effectively with patients. I researched the Teach Back technique as a method to ensure that my patients have understood changes that I am making in their pain medication during a consultation. I can also use this technique to aid patients to take responsibility for their self-management of their pain. I normally reinforce any changes I have made to medication both verbally and written at the end of my consultation as I have found that patients like to have a written care plan. As a result of learning the Teach Back technique, I have decided to incorporate this into my consultations to ensure that patients have fully understood any changes to medications.

I have employed this technique for 2 months now and patients have accepted this and are finding it helpful in checking their understanding of their ongoing care. It also allows them to ask questions and discuss concerns. I have also found that patients who are able to use this technique in relation to their self-management of pain are more likely to make the changes we have discussed. It appears that if they verbalise the changes we have discussed then they are more likely to engage with the agreed goals, set realistic goals in self-management of stress and physical activities for themselves and implement these changes.

### Example 2

Q13. Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals that has benefited your patients or service users.

I am currently working in primary care within several GP practices with many different multidisciplinary teams and several pharmacists. I wanted to improve the communication between the health board and the practices I work in. I asked whether the pharmacy team (myself and the pharmacists) could have a user group set up on the system (Emis Web) so that questions/queries asked by the practice (via tasks) can be dealt with in a timely manner.

Historically the practice have sent tasks to individuals and these tasks were not dealt with in a timely manner due to that member of staff being on holiday, off sick or left the practice. The idea of the user group is when a member of the practice sends a task they send it to the 'medicines management' user group, rather than individuals, and all the staff assigned to that user group get to see the task.

In doing this the amount of paper queries in the pharmacy tray has decreased dramatically and the practice have informed me that sending tasks to the user group are answered more timely than before. Also with doing this there is an electronic paper trail and all the tasks are attached to each individual patient's records.

In a non-dispensing GP practice I work in I decided to develop a quarterly newsletter for the practice to inform them of the work the health board are doing and what work there is in the pipeline. The newsletter consists of recent switches and preferred brands when prescribing, what not to prescribe, such as sharpsbin (due to the sharps bin exchange scheme in the community pharmacy) and graphs to inform them on how they are doing with their projects

for the year. (reducing antibiotics and proton pump inhibitors). This newsletter was originally only sent to receptionists as a 'prescribing tips' newsletter. I wanted to send this letter out to the whole practice so that we are all able to sing from the same hymn sheet. The newsletter is sent electronically via Emis Web internal mail and several paper copies are done and left in the staff room, receptionist areas. I have noticed with sending out this newsletter that the scriptswitch rejections have decreased and the practices spend is slowing down. Hopefully over time it would be nice to add a clinical section in for the GPs nurses and this is something that the practice pharmacist is going to look into.

### Example 3

Q13. Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals that has benefited your patients or service users.

As a healthy living pharmacy we adhere to the monthly displays which promote various different aspects health. During the summer months we had a display relating to skin care. This covered everything from sun care to eczema. However, whilst I watched customers it became apparent that this use of communication was failing. Many people waiting in the pharmacy would sit on their mobile phones and very few would actually look at the display. Therefore as a pharmacy we decided that these displays alone weren't enough. Although a valid tool it didn't allow for full involvement and truly good communication about health promotion. We therefore hosted our own promotion day which centred around skincare.

The promotion day itself was a chance for me to really speak out to customers (not only in the pharmacy but also in the wider area). Companies were contacted and free samples were made available to the public so that I, alongside other members of staff, could further discuss treatment options for their skin problems. It was a massive success, with great patient involvement.

This was the first time as a pharmacy that we tried something like this and the first time I have been involved in organising and attending such an event. Ultimately, I used it as a tool to better communicate with our customers and to really promote good health; to engage with the community and ensure that the voice of our pharmacy was heard. It was also a great opportunity for us as staff. This new style of communication challenged not only myself but us as a whole (many of the staff had not been involved in this level of public speaking prior to the event), whilst also ensuring that our training on skincare was up-to-date. It also boosted the confidence of the staff in talking about public health and I have seen an improvement in their daily communications with customers alongside my own consultations as well, which I feel have increased confidence.

Due to the success, health promotion days will become a regular aspect of our pharmacy. Better communicating with customers regarding their health is imperative. There will also be a general push whilst doing OTC sales and consultations to communicate with people about our health promotions, discussing up-and-coming events alongside general enquires which are raised by our renewed enthusiasm.

This new approach to how we communicate as a department to the public has already been seen to improve patient participation in our campaigns. From speaking to customers during the day and afterwards it was clear to me that this method was highly effective not only in the health promotion but also in their views on us as a pharmacy. It also directly benefited some customers with referrals to the GP about their issues which otherwise may have been left for a longer period of time, resulting in more discomfort for the patient or a worsening of condition showing that by changing the ways in which we communicate effectively can have a positive result.

## Appendix 11 Focus group learning record examples

### Example 1: Planned Learning

What are you planning to learn?	How are you planning to learn it?	Give an example of how this learning benefited your patients or service users
<p>I have been involved in the development of a CPD course specifically aimed at pharmacists who may want to work as primary care pharmacists in a general practice. My role on the project is to act as the pharmacist representative of the research team within the medical school. I have need to advise on the potential needs of a pharmacist to have an extended role in a GP team. This has included many clinical area and also areas of communication and consultation skills. The most popular training needs of the pharmacists was that of clinical skills. As a community pharmacist I had little knowledge of the requirements of a practice pharmacist in terms of additional clinical skills. I needed to learn the what particular skills might be of value to a pharmacist in general practice.</p>	<p>I started exploring my own thoughts of what I would find useful, even in a community pharmacy setting. Common minor ailments present at the pharmacy and it would be useful on some occasions to have more tools for practice. The initial thoughts were blood pressure, eyes, ENT, and respiratory. Beyond this I spoke to pharmacists who already work in a GP surgery and discovered the wide range of skills that they had developed. I then spoke to GP colleagues and asked them what skills they thought would be most useful to a practice pharmacist. Having gained all my evidence, I then collaborated with my GP colleague on the project, and we designed a set of skills which we could teach pharmacist within the medical school. I arranged a meeting with the team in the Clinical Skills Resource Centre. We discussed the range of skills we deemed appropriate for pharmacists to need for further integration into the practice team. We arranged two mornings, one in March 2016, and one in July 2016. I had to learn, with the help of my colleague, the basic skills before my pharmacist colleagues on the course attended the day.</p>	<p>In March 2016 we had a clinical skills training morning on skills necessary to support long term condition review clinics. Vital signs Temp, Pulse, Respiratory rate, BP ENT Ear inspection, throat swab, lymph nodes Eye examination Diabetic leg examination We asked colleagues for feedback from the morning. They all scored it excellent for use in practice, and content. They gave constructive feedback and suggested that more time to practice would have been useful. In July 2016 we arranged for real patients to attend the day to give authenticity and professionalism to the training session. As a result of feedback we concentrated on more time for less content. Chest examination and use of a stethoscope was considered very important and the pharmacists were given plenty of opportunity to practice. I was aware of the time between sessions from March to July, and again with feedback I suggested we recapped the previous skills by allowing the pharmacists to practice them on the patients. I designed a prompt sheet as a reminder of the previous skills. Feedback from both sessions has been very positive. The participants were grateful for my prompt sheet and many of them said they would use it as an aide memoire All the pharmacists said that they would use some, if not all of the skills, even in a community pharmacist. One community pharmacist has invested in clinical skills equipment for his consultation room to facilitate additional services such as MURs and NMSs Other comments were that perhaps all undergraduate pharmacists should learn basic clinical skills which would be useful in practice. It has been very useful to my learning, and I use many of the skills when I work as a locum in community pharmacies in</p>

		the South West
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### Example 2: Planned Learning

What are you planning to learn?	How are you planning to learn it?	Give an example of how this learning benefited your patients or service users
To have a better understanding of dysphagia and how it affects the ability of a patient to take oral medication, the recommendations for prescribing liquid medication and the consequences of prescribers authorising medication to be used off licence for all involved in the process, prescribers, pharmacists, carers and patients.	To complete the Future Learn Massive Open Online Course (MOOC) from UEA entitled DYSPHAGIA: SWALLOWING DIFFICULTIES AND MEDICINES.	This is an area I come across on a regular basis whilst working in the supply of medication to care homes and the advice I give on managing medication whilst visiting the homes. The revision of the subject, particularly the techniques that might be used to administer medication by crushing or other alteration of the dose form has given me a better focus for questioning and educating carers and nurses on the best way to administer medication if this is required.

### Example 3: Planned Learning

What are you planning to learn?	How are you planning to learn it?	Give an example of how this learning benefited your patients or service users
I want to learn more about the newer inhalers and how they fit into the BTS asthma guidelines. This learning is relevant to me as I dispense inhalers and conduct Medication use reviews. This will allow me to counsel patients for safe use of inhalers and check inhaler is correct for optimum disease control.	I am attending a Pharmacist Update training day. Read Nice and BTS guidelines.	My knowledge of inhalers and guidelines has improved. This has raised my confidence in explaining and checking inhaler technique with all inhalers. I am able to check for common mistakes and suggest improvement. I have been able to explain the Tidal breathing technique with the use of a spacer device. If there is doubt the inhaler chosen is not used correctly by the service user, I can use a Dial check device (this monitors the speed of the breath) to confirm. There was a section on 'Learning from asthma deaths' at the study day. As a result I reminded the Healthcare staff of avoiding NSAIDs in Asthmatic patients. I also check patients have and use their personalised asthma action plans and rescue packs. A direct example of how this training benefited a service user was during an medication review. A patient was using Relvar at step 2. Relvar contains a medium to high potency steroid which fits in at step 4 of the guidelines. This inhaler was changed by the asthma nurse to

		Fostair with no deterioration to his Asthma.
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#### Example 4: Planned Learning

What are you planning to learn?	How are you planning to learn it?	Give an example of how this learning benefited your patients or service users
I am planning to learn about anticoagulation post op in planned orthopaedics and also the perioperative management of patients on anticoagulants	I am planning to learn it by: Self learning using article : Perioperative management of patients on anticoagulants ( Clinical pharmacist Vol 8 No 4 April 2016) Reading Trust clinical guidelines on: Perioperative management of drugs in orthopaedics Orthopaedic guidelines for post operative anticoagulation Trust NOAC guidelines and pathway Discussion with orthopaedic lead pharmacist & anaesthetist	I had been asked to provide clinical cover to an elective orthopaedic ward. I have covered the ward this week and been able to confidently make sure that patients have the correct thromboprophylaxis whilst in hospital and for the appropriate time following their surgical procedure on discharge from hospital. In addition I have been able to counsel patients about their NOAC to ensure safe discharge

#### Example 5: Unplanned Learning

Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills.	Give an example of how this learning benefited your patients or service users.
I have read the NICE guidance on controlled drugs; safe use and management published on 12 April 2016. I also read the NICE bites on the same guidance. I then discussed it at the Medicine management group in the hospice and with a consultant. I have also discussed it with the South East group of the Palliative care pharmacist network group.	I am more aware of issues relating to the destruction of controlled drugs. We will change our policy to reflect this guidance. This will provide more robust systems for the destruction of CDs. It has also confirmed our good practice in regards to controlled drugs. I am also discussing with the nursing staff changing the times of the nurse CD stock checks. This would enable more nursing staff to attend to the patients and so improve patient care.

#### Example 6: Unplanned Learning

Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills.	Give an example of how this learning benefited your patients or service users.
A new clinical guideline for the management of ACS was produced by SIGN. It replaced the previous SIGN 93 guideline. I was required to review the new guideline and highlight any new recommendations that would affect our current management and treatment pathways.	The new guidelines had some new recommendations based on the available evidence that indicated that short-term (3–6 months) therapy with dual antiplatelet therapy is associated with either equal or lower rates of all cause mortality compared with longer durations (≥12 months), but approximately half the risk of major bleeding. This is a significant change to practice as patients currently receive 912 months therapy. Given this it was necessary to arrange a clinical update for GP's and to run a search in practices to identify which patients would need their medication reviewing so that they were not exposed to possible increased harm by continuing dual therapy for longer than necessary.

### Example 7: Unplanned Learning

<b>Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills.</b>	<b>Give an example of how this learning benefited your patients or service users.</b>
<p>I am a member of the Pharmacy Senior Management Team (SMT) in a large teaching hospital. A team 'time out' was organised in order to discuss how best our department can address the recommendations within the Carter Report. Prior to attending the 'time out' I read the pharmacy section of the Carter Report and then reflected upon how we could address this locally. During the 'time out', the Trust project lead for the Carter Report came to speak to us with regard to the wider impacts of the Carter Report across the whole Trust and to answer any questions that we may have.</p>	<p>As a result of my prior reading and listening to the Trust Lead for the Carter Report, I was able to make a number of suggestions with regard to improving the amount of patient facing work that is undertaken by pharmacy staff. These suggestions, if implemented, will ultimately improve patient care through increased clinical contact with pharmacy staff. I also proposed that we directly seek suggestions from pharmacy staff with regard to the Carter Report, in case staff had any suggestions that we hadn't considered. This would also hopefully engage staff with the Carter Report and any associated changes to working practices that may follow. I feel that through engaging staff, we will be more effective as a department in addressing the Carter Report and thus will be able to provide an improved clinical service to our patients. Following the 'time out', I therefore created a staff survey that we have implemented to collect staff suggestions concerning the Carter Report.</p>

### Example 8: Unplanned Learning

<b>Describe an unplanned event or activity that enabled you to learn something new or refresh your knowledge or skills.</b>	<b>Give an example of how this learning benefited your patients or service users.</b>
<p>During a routine visit to one of the MHSOP wards at the hospital I work at, whilst performing my clinical checks on the administration charts I noticed a drug prescribed I had never seen before. I picked up my BNF edition 70 to look up the medication prescribed, only to find the drug was not listed. I made a note of the drug Vortioxetine the strength time prescribed, and other drugs the patient was on also the allergy status of the patient. After completing the rest of my duties I returned to pharmacy to learn more about this drug. I have learnt that Vortioxetine is approved for use by NICE as a 3rd line antidepressant in people who have had an inadequate response to 2 previous antidepressants for the treatment of a major depressive episode. I have read the guidance by NICE and EMC product characteristics. I have learnt the dosage regimes, some of drugs which may have interactions with Vortioxetine and some of the possible Adverse reactions to this drug.</p>	<p>My increased knowledge of this drug and knowledge of possible interactions with other medicines will benefit the patients when counselling for leave or discharge. I will be able to advise patients of some of the common adverse reactions that could be experienced, but are usually mild and usually occur if at all, within the first 2 weeks of treatment. Sharing information with the patients and giving them the opportunity to be involved in the decision making will help to aid compliance. I was actually asked by the patient would she be okay to take her sleeping tablet with this medication,, after checking with the pharmacist I was able to go back to the patient with the answer who thanked me for my help.</p>



### Example 9: Case Study

**Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals that has benefited your patients or service users.**

When dispensing chemotherapy proformas I have noticed that the physical stock levels of some cytotoxic medicines have been incorrect against our electronic records particularly for medicines that have similar packaging and tablets or capsules of similar appearance to the same medicine of different strengths ( for example etoposide 50 mg and 100 mg capsules and capecitabine 150 mg and 500 mg tablets ). I raised this with the dispensary manager and other members of staff who frequently dispense these medicines. I suggested that to prevent stock balance discrepancies we could start checking the physical balance against the electronic balance every time cytotoxic medicines are dispensed ( in a similar way to the way we check controlled drugs ). Some members of staff felt that this would lengthen the dispensing process. I discussed this with the concerned team members acknowledging their opinion and agreeing that in the short-term a small amount of time would be taken up in the dispensing process but, in the long term this process would improve patient safety and reduced the need to conduct investigations. The other team members recognised the benefits of this procedure and that it would prevent dispensing errors and reduce the time and need to investigate discrepancies. It was agreed amongst the team that checking of physical stock levels against electronic stock levels when dispensing cytotoxic medicine would be implemented into daily practice.

### Example 10: Case Study

**Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals that has benefited your patients or service users.**

I have tried to adopt a coaching style to my consultations. I have attended a number of sessions about patient consultation and how to collaborate with patients to make shared decisions. One example of this is a patient who was admitted with ACS. He also had significant chronic pain issues. Early that day he had spoken to medics and they had caused significant anguish to him because they had not addressed his concerns about his medications. I took time to understand his needs and concerns. This allowed us to come to a shared understanding about how to proceed. We focussed on addressing his concerns about the new medication he was started on for ACS, who this would affect his long term chronic pain meds and what the short term plan for his medications were leading up to the cardio angio. I then explained how we would manage his pain after this and how he needed to continue his review with the chronic pain team. By understanding the patients concerns, actively listening to his views and tailoring the information and advice I managed to reassure him of the plan for his medications. He thanked me for spending the time with him and also felt I had sorted his problems that had got him frustrated with the medical staff. I felt that my learning about a more open coaching style of consultation had allowed me to far better communicate with this patient and provide them with the pharmaceutical care they required.

### Example 11: Case Study

**Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals that has benefited your patients or service users.**

As part of my role in authoring clinical articles for primary healthcare professionals, I had to learn about emergency contraception. I did this through reading all the latest guidelines, systematic reviews, articles and product information. This enabled me to write on the subject and provide advice to primary healthcare professionals. Thereafter I was able to write a CPD quiz for pharmacists for my website to help refresh and improve their knowledge of emergency contraception to ultimately benefit patients. In addition, I can also put this information into practice, providing appropriate advice to patients directly, when I do occasional locum work.

### Example 12: Case Study

**Give an example of a change you have made to your practice this year in the context of Standard 3 of the Standards for Pharmacy Professionals that has benefited your patients or service users.**

I have completed customer complaints training this year to enable me to handle phone calls from members of the public more effectively. This has taught me the benefits of listening to patients and that saying sorry to the patient is not an admittance of any guilt. When taking a recent customer complaint over the telephone I was able to calm a very irate patient by using my newly acquired skills. I was able to apologise for the negative experience that he was having and was able to speak to him in a calm manner to reach an outcome that he was satisfied with. It was important that I provided a very clear explanation of the steps that I would take to look into his complaint and that I gave timescales for getting back to him with a response. The end result was a positive one for the patient who followed up with a phone call to express his gratitude to me for handling his complaint so effectively.

### Example 13: Peer Discussion

**Describe how has this peer discussion changed your practice for the benefit of your patients or service users.**

This peer discussion has helped me to understand how I can improve the way in which we train Preregistration Pharmacy Technicians and Registered Pharmacy Technicians to ensure that training is documented and that the trainee understands the purpose of the training and what is expected of them. My peer has been undertaking training in Coaching and I agreed to be one of her 'Clients'. The session that we had enabled me to look objectively at how we currently managed training for technicians and to consider how I could introduce and implement changes that would improve the training and enable the technicians to provide a better quality Pharmacy service for our users.

### Example 14: Peer Discussion

**Describe how has this peer discussion changed your practice for the benefit of your patients or service users.**

J... and I have discussed how we manage patients with HIV on medication who are travelling to a malaria risk area. We reviewed the antimalarial drugs and their interactions with HIV treatments. there are many drug interactions and additionally there are contraindications if the patient has other concomitant health issues. These combinations often result in no antimalarials being suitable for patients, particularly if they present with less than two weeks before travel. We considered whether it would be appropriate to offer this cohort of patients emergency standby treatment and we decided that this was not appropriate as there is very strict guidance that needs to be followed and this would be a difficult consult to undertake with new to service patients. Many of the emergency drugs also have interactions with HIV medicines as well. We decided the best way to manage these patients is to discuss all of the risks of travelling to malaria regions and that we ensure the patients understand the need to discuss their plans with their HIV consultant. We provide patients with information they can give to the consultant, including the option to contact the malaria reference laboratory. We feel that although there are many patients that we can't prescribe for we make sure that the patients are appropriately signposted.



### Example 15: Peer Discussion

**Describe how has this peer discussion changed your practice for the benefit of your patients or service users.**

I chose another pharmacist store manager to be my peer as I have a good relationship with her and she has more experience in the role. My peer discussion helped me think about prioritising my workload, in order that I am in a good position to support patients' with services. I was feeling that I did not have time to complete asthma LES reviews and CMS interventions with patients that I felt would have benefitted from these services. This was partly due to the manager workload I was juggling and it was taking away from spending quality time with my patients. As a result of the discussion, I now know how another store manager prioritises workload. Vicki sets aside specific time periods where she will focus on her managerial tasks every day. As she knows her business well, she knows when is appropriate to carry out her managerial tasks in order that her patients' do not suffer. In addition, she has coached her team to adopt the healthcare people model, advocated by Boots, in order that her team support her and she is free to speak with her patients. This made me reflect on my own working environment and I realised that I was perhaps doing too many things myself and not coaching and then worrying about when I would do all the tasks rather than planning in the time. Having identified a need to change to benefit my patients, I have since set aside a time frame where I look at managerial related jobs. I am also now coaching my healthcare assistant with her dispenser training and have support from my registered technician. The aforementioned will most definitely have a direct benefit to my patients as I will be more available and my team will be trained to a higher level. Already, I have had time to talk to one of my patients about his inhaler technique through the new asthma LES and have documented several CMS new medication interventions.

### Example 16: Peer Discussion

**Describe how has this peer discussion changed your practice for the benefit of your patients or service users.**

I decided to have peer discussion with my line manager regarding the pharmacy services provided to an offsite elderly care ward. I chose my line manager because of her experience at the Trust, understanding of clinical pharmacy on the wards and her awareness of the challenges of working on an offsite ward. My line manager would be able to provide useful guidance and advice. My peer discussion focused on how pharmacy services to the offsite elderly ward could be improved. This involved reviewing current practice and how changes could be made to improve quality, efficiency and safety. I was also able to reflect on what had been tried before and what went well and what went not as well including feedback from the ward Medicines Management Technician, Assistant Technical Officer and nursing staff. I found the discussion very insightful and have used it to guide changes to my own practice and review areas for further learning and development. For example, communication and handover to fellow pharmacy colleagues was identified as an issue and I now ensure that a clear handover of patients is left in the pharmacy handover folder on the ward. It provides a useful method to communicate with each other as we don't visit the ward at the same time but if something needs to be completed or followed up, this is all communicated via this method. I have shared my learning with other members of the team who work on the offsite ward so that they are aware of the changes made and I have also highlighted the need for continual review and feedback. I have received good feedback from the nursing staff especially with regards to better stock management so patients have access to medicines in a timely manner. As a result of the peer discussion and speaking to the ward consultant I have decided to enrol on a nonmedical prescribing course.





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