Revalidation in Pharmacy: Evaluation of appraisal and alternative sources of evidence

Volume 2: Supporting evidence

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Abstract

Following a number of high profile cases highlighting failures in doctors’ competence and performance, and the subsequent publication of ‘Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century,’ systems of revalidation are to be implemented for all healthcare professionals. Revalidation has been described as a mechanism that allows health professionals to demonstrate that they remain up-to-date and fit to practise, thus ensuring public trust and safety. Different approaches to revalidation are possible and, whilst Continuing Professional Development (CPD) is likely to form a key element, other sources of evidence are possible. The use of appraisals, for example, is being implemented for doctors, and there are other more pharmacy specific structures which may also play a role.

Project aims
The aim of this project was to evaluate the use of appraisals and alternative sources of evidence for the purpose of revalidation in pharmacy in Great Britain. The objectives were to:

- Gather information on existing structures, processes, and items covered in appraisals implemented in the main sectors in pharmacy, and explore the views of pharmacy employers on if, and how, appraisals could feed into revalidation in future;
- Explore other possible sources and structures for evidence gathering for the purpose of revalidation, which already exist in pharmacy
- Examine the views of practising pharmacists and registered pharmacy technicians working in all sectors on assessment methods and processes for the purpose of revalidation – in England, Scotland and Wales;

Methods
A mixed-method design, combining qualitative and quantitative methods, was used. Semi-structured interviews and/or questionnaire surveys were conducted with pharmacy employees and employers in different sectors providing NHS services (i.e. community pharmacies, hospital trusts, primary care organisations), in the sector of academic pharmacy teaching (i.e. schools of pharmacy), and in the pharmaceutical
those involved in other processes of relevant evidence gathering (i.e. the RPSGB Inspectorate and PCT contract monitoring) were also interviewed.

**Key findings**

**Revalidation standards:** A clear understanding of what revalidation is and involves will require clear standards against which any assessment would have to be made. The current lack of these had implications for respondents’ ability to comment on revalidation and the potential usefulness or adaptability of existing systems, such as appraisals or inspection and contract monitoring processes.

**Employer appraisals:** Despite employer appraisals being widespread in all sectors involved in this study, those who were not employed, such as locums or independent pharmacy owners, did not fall under these management and appraisal structures. Appraisals commonly focused on performance specific to the sector or organisation in question. In community pharmacy and the pharmaceutical industry, there was a clear focus on business targets; in academia, the focus was on academic performance. Issues of clinical or professional performance did not commonly feature, other than in primary and secondary NHS organisations involved. Appraisals as well as inspection and monitoring visits were seen as supportive and formative, which created a potential conflict with a more summative assessment approach.

**The appraiser/assessor:** There were some differences of opinion as to who should be responsible for an individual’s fitness to practise, with many stressing the individual’s own responsibility. Respondents also raised concerns about their own ability to assess another individual’s fitness to practise, and acknowledged requirements for appropriate training and consistent, objective and fair approaches. The importance of role understanding was raised, so was whether an appraiser or assessor would need to be a pharmacy professional. Overall, the varied nature of pharmacy and its different sectors was acknowledged, as well as the difficulties this potentially poses for revalidation.

**Premises versus individuals:** The main issue with inspection and monitoring processes was that they are geared towards pharmacy premises rather than individual pharmacy professionals. Apart from some exceptions where individuals and premises may be relatively closely linked, such as owners, these systems did not appear to be easily adaptable to revalidation, other than to support employers and governance.
Acknowledgements

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We also express our thanks to the National Clinical Assessment Service (NCAS), who funded the costs of collecting and processing some of the data, namely the 30 initial interviews with community pharmacy stakeholders, and the survey of NHS hospital trusts and primary care organisations. We would also like to thank Dr Liz Seston and Ms Julie Prescott, who – as members of staff in CPWS – worked on the NCAS funded study on pharmacists with poor performance, for their help with questionnaire design and administration of the survey to hospital (trusts) and primary care organisations. We are grateful to Jane Glover, whilst a member of staff in CPWS, for undertaking some of the literature searches and conducting some interviews with the RPSGB inspectorate and schools of pharmacy.

Many thanks go to Helen Potter, who is in the process of completing her PhD under the supervision of Professors Hassell and Noyce. Based on detailed qualitative interviews, she undertook a large, representative survey of pharmacists and pharmacy technicians entitled ‘revalidation: identifying performance criteria for pharmacists / pharmacy technicians.’ Being able to analyse and share some of the findings from this survey has added great benefit to the commissioner, the RPSGB, as it has provided very relevant insights from the perspective of pharmacy professionals in all sectors.

Finally, we would like to thank the individuals in all the different stakeholder organisations who agree to be interviewed or took the time to complete a survey. Without their help and willingness to share their experiences and views, this study would not have been possible.
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1 Practitioner’s opinions about revalidation: secondary analysis of a survey of pharmacists and pharmacy technicians (conducted as part of Helen Potter’s PhD)

1.1 Introduction

This report contains findings from surveys of pharmacists’ and pharmacy technicians’ opinions about revalidation. The surveys were conducted as part of a programme of work for a PhD study undertaken by Helen Potter, a postgraduate student within the Centre for Pharmacy Workforce Studies, in the School of Pharmacy and Pharmaceutical Sciences at The University of Manchester. The research team agreed to share the analysis of the survey data with the RPSGB in light of its relevance to the commission we were contracted to undertake. The student is still writing the thesis so the work remains unpublished at this time. Thus, in the interests of preserving the student’s intellectual ownership of the material, this report provides only a basic description of the research process, and only the data of direct relevance to the current commission are reported. These include:

- competencies that should be demonstrated for revalidation
- how pharmacists and pharmacy technicians could be assessed
- who should conduct the assessment
- how frequently the assessment should be carried out
- what type of consequences may be faced if any assessment is failed

1.2 Method

1.2.1 Questionnaire design and distribution

Two separate, but similar, questionnaires were designed and sent to a random sample of pharmacy technicians and pharmacists practising in GB. The questionnaires were constructed based on the results of qualitative data obtained from focus groups and semi-structured interviews conducted by Helen Potter in the early stages of the PhD, and from relevant research literature about revalidation in other health professions. The majority of questions used closed scaled responses, but one open question at the end of the questionnaire gave respondents an
opportunity to provide narrative responses about any of the issues covered. The questionnaires were piloted, both for substantive content and ease of completion. Probability sampling was used as the sampling strategy to recruit participants, so that the cohort included people from community pharmacy, hospitals, primary care organisations, academia, and industry, and only pharmacists and pharmacy technicians registered with the RPSGB, who were currently on the practising register and were residing in England, Scotland or Wales were contacted to complete the questionnaire. The study received ethics committee approval from Tameside and Glossop local research ethics committee on February 25th, 2009.

A total of 4,640 pharmacists and pharmacy technicians were selected to take part – 3,902 pharmacists and 738 pharmacy technicians, representing 10% of the practising register from each profession. Some data was excluded from this sample due to incomplete questionnaires, requests to withdraw from the study and current unemployment, reducing the overall sample to 4,565 (3,834 pharmacists and 731 pharmacy technicians). Return rates without a reminder totalled 816, and after a reminder was sent to remaining candidates, a further 390 questionnaires were returned, giving a total of 1206 received overall. 966 pharmacists and 240 pharmacy technicians completed the questionnaire (a response rate of 26.4 %) which was distributed to participants by post between April and July, 2009.

There are a number of possible explanations for the low response rate: (i) at the time of the study, and even now, practitioners’ knowledge about revalidation was at best basic, so it is possible that the topic had low saliency for pharmacists and pharmacy technicians invited to take part in the study; (ii) the questionnaire was long and took approximately 30 minutes to complete. Project resources allowed for only one reminder follow-up, so opportunities to increase the response rate further were time and resource limited. Despite this response rate, respondents are nevertheless broadly representative of pharmacy practitioners registered with the RPSGB, the sample size is sufficiently large to allow for statistical comparisons to be drawn between respondents, and the extensive pilot work invested by the student into the design of the questionnaire give the research team confidence that the findings still have merit and should be of interest to the commissioners. Moreover, given the paucity of research on the topic of pharmacy revalidation, results from these surveys
provide a starting point to inform future policy and a future research agenda on revalidation.

1.2.2 Data analysis

The response categories for questions, which originally provided a five-point scale, were collapsed into three to ensure large cell counts for analysis: ‘strongly agree’ and ‘agree’ responses were recoded into ‘agree’; ‘strongly disagree’ and ‘disagree’ were recoded into ‘disagree.’ The third response type was either ‘neither agree or disagree’ or ‘not applicable to me’. For some questions the response type changed from ‘agree’/’disagree’ to ‘important’/’unimportant’ as a way of responding, and these were collapsed in a similar fashion. There were also occasions when individuals did not provide a response to a question leading to cases of missing data. The removal of irrelevant data, and missing data caused a reduction in sample size by a small fraction for analyses of some questions.

Responses to questions in each section of the questionnaire were collated for all individuals for whom the section was applicable; the overall levels of agreement / importance to the questions posed are provided for the whole sample first. Different groups of respondents were then compared. For example, sections 1.3.2 to 0 focus on the differences between responses of pharmacists and pharmacy technicians, followed by comparisons between pharmacists and pharmacy technicians within community and hospital pharmacy – the two biggest sectors in pharmacy. Sections 1.3.5 to 1.3.7 focus on findings relating to smaller, more specific groups of respondents (e.g. self employed pharmacists).

Chi-square tests were used to test for differences in the distributions of responses between groups being compared. A significance level was set at 5% (two-tailed). Values of less than .05 are therefore significant and show that there is a < 5% chance of different results occurring from a full population sample of the groups analysed. Significant outcomes between the groups being considered are highlighted in bold font within the tables of results.
1.3 Results

This section first provides an overview of the demographics of the pharmacists and pharmacy technicians who completed the questionnaire. Tables of results displaying the findings from all respondents on the substantive questions posed in the questionnaires follow on from respondents' demographic information. After that, a brief summary of the main differences found between specific groups of respondents (e.g. pharmacists and pharmacy technicians; community and hospital pharmacy) are provided.

1.3.1 Demographic characteristics of respondents

1.3.1.1 Pharmacists

The age of the 966 pharmacist respondents ranged from 23 to 78 with a mean of 43.68 and standard deviation of 12.06. Almost two-thirds (63.6%) of the respondents were female. The majority of pharmacists (67.5%) were employees, 23% were self-employed (i.e. locum) and 9.5% were both self-employed and an employee. Over half of respondents worked within community pharmacy (57.6%), with hospitals being the next most common workplace for respondents (24%). Only around one-tenth (9.3%) of respondents worked in primary care, 3.7% worked within industry, 1.7% within academia, and 3.8% stated ‘other,’ which represented workplaces such as prisons, health authorities and regulatory bodies.

The demographic characteristics of pharmacist respondents to this survey are similar to those of respondents from the 2008 pharmacist census. Respondents of the census had an age range of 21 to 101 years with a mean of 44 years and standard deviation of 14.32. The majority (65.2%) of pharmacists reported that they were an employee, approximately one quarter (27.4%) of actively employed pharmacists were self-employed, and 7.4% of pharmacists reported that they were both employees and self-employed. The majority of respondents (71%) from the census worked within community pharmacy, 21.4% within hospitals, 7.2% within primary care, 4.1% within industry, 2.8% in academia, and 3.8% stated ‘other’.
1.3.1.2 Pharmacy Technicians

The age of the 240 pharmacy technician respondents ranged from 23 to 68 with a mean of 43.80 and standard deviation of 8.85. The vast majority (93.7%) of the respondents were female. Nearly all pharmacy technicians (95%) were an employee, 2.9% were both self-employed and an employee, and 2.1% were self-employed. Almost two-thirds of respondents worked within community pharmacy (64.1%), with hospitals being the next most common workplace for respondents (20.7%). Out of the remaining pharmacy technicians, 6.8% of respondents worked in primary care, 3% worked within industry, 1.7% within academia, and 3.8% stated ‘other,’ which included workplaces such as prisons, and private hospitals. A census has not yet been completed for pharmacy technicians so no comparison can be made between demographic data from this questionnaire and census data.

1.3.2 How competencies for revalidation could be assessed

Respondents were asked to consider how competencies for revalidation could be assessed and to decide how much they agree or disagree with the statements shown in the left-hand column of Table 1.

The first finding of note here is that a large majority of all respondents (69.4%) agreed that revalidation should be an ongoing, continuous process rather than a scheduled periodic event. This is in keeping with the current view emerging from the profession. Second, and perhaps not surprising given that CPD is now mandatory for pharmacists, a substantial majority of respondents (86%) agreed that CPD should form part of the evidence for revalidation. Interestingly, appraisals also received a favourable opinion with 75% of all respondents agreeing that a fitness to practice appraisal could be used to assess competencies for revalidation. Evidence gathered from work colleagues and peers was also relatively popular (60% agreement). Third, using information gathered from mystery shoppers in the community pharmacy setting was not popular, and including feedback from patients to inform the assessment of competencies also recorded comparatively high levels of disagreement from respondents (39%).
Table 1: Respondents’ views on how competencies for revalidation could be assessed

<table>
<thead>
<tr>
<th></th>
<th>Agree (%)</th>
<th>Neither Agree or Disagree (%)</th>
<th>Disagree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Revalidation should be ongoing, a continuous process as opposed to a comprehensive assessment event scheduled periodically</td>
<td>69.4</td>
<td>17.9</td>
<td>12.6</td>
</tr>
<tr>
<td>b) For revalidation, I should have a portfolio of written evidence of good practice</td>
<td>50.0</td>
<td>25.0</td>
<td>25.0</td>
</tr>
<tr>
<td>c) Evidence gathered towards revalidation should include feedback from patients</td>
<td>27.8</td>
<td>33.2</td>
<td>39.0</td>
</tr>
<tr>
<td>d) Evidence gathered towards revalidation should include feedback from work colleagues and peers</td>
<td>59.7</td>
<td>23.3</td>
<td>17.0</td>
</tr>
<tr>
<td>e) Revalidation should include providing evidence of a fitness to practise appraisal (i.e. not focused on financial or performance targets but on my ability to perform as a pharmacist)</td>
<td>75.4</td>
<td>15.9</td>
<td>8.7</td>
</tr>
<tr>
<td>f) Revalidation should include providing evidence of Continuing Professional Development that is relevant to my practice</td>
<td>86.3</td>
<td>8.9</td>
<td>4.8</td>
</tr>
<tr>
<td>g) For counselling skills I should be observed in practice</td>
<td>47.6</td>
<td>29.8</td>
<td>22.7</td>
</tr>
<tr>
<td>h) In the community setting, information from mystery shoppers should form part of the evidence gathered for revalidation</td>
<td>24.8</td>
<td>27.3</td>
<td>47.9</td>
</tr>
<tr>
<td>i) I should be able to self certify that I am fit to practise and not have to undergo any form of assessment</td>
<td>40.9</td>
<td>23.4</td>
<td>35.7</td>
</tr>
</tbody>
</table>

* significant difference between pharmacists and pharmacy technicians
# significant difference between community and hospital pharmacy

1.3.2.1 Pharmacists and Pharmacy Technicians

Pharmacists and pharmacy technicians recorded statistically significant different opinions on a number of issues around how competencies for revalidation could be assessed. Standing out in particular were their opinions on whether or not counselling skills should be observed in practice (statement g in Table 1)
The majority of pharmacy technicians agreed with this proposal (62.1%) whereas less than half of pharmacists agreed (44.1%), leading to a highly significant result from the chi-square analysis ($p < .001$). Although the size of the difference was much smaller, larger proportions of pharmacy technicians compared with pharmacists also agreed with statements $d$, $e$, and $h$. The reverse is true for the statement about CPD, with more pharmacists in favour of using CPD in a revalidation process than technicians. Agree responses between pharmacists and pharmacy technicians for statements with a significant difference between these individuals are illustrated in Figure 1.

Figure 1: Assessment for revalidation: significant differences between Pharmacists and Pharmacy Technicians

![Bar chart showing significant differences between pharmacists and pharmacy technicians on various statements related to revalidation](chart.png)

That technicians are more at ease with the proposals to use observation, appraisal and feedback from colleagues/peers as part of a revalidation process is perhaps not unexpected, given that they are more likely to be assessed in their present roles using these sorts of processes already.

1.3.2.2 Community and Hospital Pharmacy

Comparisons between respondents working in the two main sectors of pharmacy demonstrated that there were significant differences on four of the nine statements...
concerning how competencies for revalidation could be assessed. More hospital pharmacy (55.7%) than community pharmacy respondents (45.7%) agreed that having a portfolio of written evidence for revalidation would be appropriate. Notable differences were also found for statement d. Significantly more respondents working in hospital pharmacy agreed with this proposal (70.7%) compared with those in community pharmacy (53.1%); and again, a greater proportion of hospital than community pharmacy respondents were more likely to agree that counselling skills should be observed in practice. Finally, when asked whether they personally should be able to self-certify they are fit to practise and not have to undergo any assessment, more community respondents (48.3%) agreed with this than those in hospital pharmacy (26.8%). Moreover, half of the respondents from hospital pharmacy disagreed with this notion, whereas 28.9% of respondents from community pharmacy disagreed. Agree responses for statements with a significant difference between these individuals between community and hospital pharmacy are illustrated in Figure 2.

Figure 2: Assessment for revalidation: significant differences between Community and Hospital Pharmacy

It is perhaps not surprising that hospital pharmacists and technicians compared with community practitioners are far more comfortable and at ease with these particular suggestions for how competencies should be assessed in a revalidation process,
since in the NHS setting these sorts of assessment processes are well embedded. In the more varied, private sector of community pharmacy, practitioners are likely to have less exposure to them.

1.3.3 Who should conduct the revalidation assessment

All participants were asked about who should carry out the revalidation assessment if competencies of the job role would require assessment for revalidation purposes. Respondents selected one option only, indicating their preference of who should undertake this assessment. The respondents’ opinions of who should conduct the revalidation assessment can be found in Table 2. These results suggest there appears to be a preference for the revalidation assessment to be conducted by the individuals’ employer as the highest percentages for each respondent group fell into this response category.

1.3.3.1 Pharmacists and Pharmacy Technicians

Statistical tests showed there was a significant difference overall between pharmacists and pharmacy technicians ($X^2 = 70.28$, $df = 5$, $p < .001$). Response differences that contributed most to these significant results were found in decisions on whether the revalidation assessment should be conducted by the individuals’ main employer (30.2% of pharmacists selected this option, whereas 58.4% pharmacy technicians selected this option).

1.3.3.2 Community and Hospital Pharmacy

Responses for respondents from community and hospital pharmacy were also significantly different ($X^2 = 46.52$, $df = 5$, $p < .001$) for these questions. Response differences that contributed most to these significant results were found in decisions about whether the revalidation assessment should be conducted by the individuals’ main employer (32.9% community pharmacy respondents selected this option, whereas 44% of hospital pharmacy respondents selected this option). Additionally, large differences were found in whether a variety of assessors from more than one source should conduct the revalidation assessment. Only 7.4% of community
pharmacy staff thought this was the best method, whereas 15.3% of hospital pharmacy staff believed this was the best option.

**Table 2: Respondents’ preferences for who should conduct the revalidation assessment**

<table>
<thead>
<tr>
<th>Proportion of Respondents (%)</th>
<th>Pharmacists</th>
<th>Pharmacy Technicians</th>
<th>Community Pharmacy</th>
<th>Hospital Pharmacy</th>
<th>All respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) My assessment should be conducted by an assessor employed by my main employer (i.e. reviewed within the NHS, within a company or organisation) who forwards a recommendation directly to the pharmacy regulator, currently the RPSGB</td>
<td>30.2</td>
<td>58.4</td>
<td>32.9</td>
<td>44.0</td>
<td>35.2</td>
</tr>
<tr>
<td>b) My assessment should be conducted independently by a senior pharmacy professional based at local level (i.e. within the geographical area where you work) who forwards a recommendation directly to the pharmacy regulator</td>
<td>13.5</td>
<td>8.6</td>
<td>14.4</td>
<td>10.9</td>
<td>12.6</td>
</tr>
<tr>
<td>c) My assessment should be conducted independently by a senior pharmacy professional from outside the geographical area where I work. This person should forward a recommendation directly to the pharmacy regulator</td>
<td>6.6</td>
<td>0.9</td>
<td>6.0</td>
<td>4.4</td>
<td>5.5</td>
</tr>
<tr>
<td>d) My assessment should be conducted directly by an assessor from the pharmacy regulator</td>
<td>14.4</td>
<td>7.3</td>
<td>14.3</td>
<td>9.8</td>
<td>13.1</td>
</tr>
<tr>
<td>e) My assessment should be conducted by a variety of assessors from more than one source (i.e. my employer, and/or an independent senior pharmacy professional, and/or the pharmacy regulator)</td>
<td>12.5</td>
<td>7.7</td>
<td>7.4</td>
<td>15.3</td>
<td>11.5</td>
</tr>
<tr>
<td>f) I don’t have a preference with regards to who should undertake my assessment</td>
<td>22.7</td>
<td>17.2</td>
<td>25</td>
<td>15.6</td>
<td>21.7</td>
</tr>
</tbody>
</table>

* significant difference between pharmacists and pharmacy technicians
# significant difference between community and hospital pharmacy
1.3.4 Importance of general issues concerning the revalidation process

Respondents were asked to think in general about a process for revalidation and consider how important the following statements were to them. Responses for the questions were divided into ‘important’ and ‘unimportant’ in the same manner as ‘agree’ and ‘disagree’ responses were consolidated and used for analysis.

Descriptive statistics for this analysis can be found in Table 3.

The majority of respondents considered all of the statements in the above table important, although there was a particularly high level of agreement with statement b, indicating that the majority of practitioners would prefer a pharmacist with an understanding of their specific role to conduct any revalidation assessment. The statement that elicited the lowest level of importance and highest level of neutral responses in comparison to the other statements was statement e. Although the majority of respondents (67.8%) considered this proposal important, almost one quarter (27.4%) provided a neutral response.

Table 3: Respondents’ views on a range of general issues concerning revalidation

<table>
<thead>
<tr>
<th>Statement</th>
<th>Important (%)</th>
<th>Neither Important or Unimportant (%)</th>
<th>Unimportant (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I would want to be responsible for collating any information/evidence required to support my revalidation</td>
<td>83.5</td>
<td>13.5</td>
<td>3.0</td>
</tr>
<tr>
<td>b) The person who conducts my assessment should be a pharmacist who has an understanding of my role</td>
<td>90.1</td>
<td>7.1</td>
<td>2.8</td>
</tr>
<tr>
<td>c) The person who conducts my assessment should be trained and accredited by the regulator</td>
<td>85.4</td>
<td>11.5</td>
<td>3.1</td>
</tr>
<tr>
<td>d) The assessment should be undertaken using a standardised revalidation tool developed by the regulator</td>
<td>81.5</td>
<td>14.6</td>
<td>3.9</td>
</tr>
<tr>
<td>e) If I do not meet the revalidation standard set by the regulator, it should be for the regulator to ultimately assess my fitness to practise</td>
<td>67.8</td>
<td>27.4</td>
<td>4.8</td>
</tr>
</tbody>
</table>

* significant difference between pharmacists and pharmacy technicians
# significant difference between community and hospital pharmacy
1.3.4.1 Pharmacist and Pharmacy Technicians

Results from this analysis revealed only one significant ($p < .001$) difference between pharmacists and technicians in this section – statement $b$. Almost all pharmacists (96%) considered it important to have a pharmacist who has an understanding of their role conduct their assessment. In contrast, 66.2% of pharmacy technicians considered this important.

1.3.4.2 Community and Hospital Pharmacy

Significant differences between community and hospital pharmacy were present for two of the statements analysed above. Again, the largest difference ($p < .001$) was found for statement $b$, when respondents were asked whether the person who conducts their assessment should be a pharmacist who has an understanding of their role. Respondents working within hospital pharmacy considered this more important than those in community pharmacy (96.2% vs. 88.5%, respectively). Significant differences were also found between respondents for statement $d$, though the differences were quite small and the significance value was marginal ($p = .030$).

1.3.5 Who should conduct the revalidation of self employed locums: Self employed pharmacists and employee pharmacists

It was considered of interest to explore the views of self employed locum pharmacists and employee pharmacists with regards to who they think should conduct the revalidation assessment for self employed locums. Pharmacy technicians were excluded from this analysis as they represented a very small number (n=5) of the self-employed locum category, so only pharmacists’ responses were considered. While all pharmacists could answer these questions, it is important to remember that a total of 219 pharmacist respondents classed themselves as self employed whereas 644 classed themselves as an employee. The remaining 91 participants stated that they were both self employed and an employee, so they were not compared for this analysis in Table 4.

The results displayed in Table 4 indicate that there are reasonably high levels of ambivalence amongst pharmacists about who should conduct the revalidation of
self employed locums. There is strong agreement however, from both employees and self-employed pharmacists alike, with the statement that self employed locums should not have their assessment conducted by an assessor from their locum agency. According to the respondents examined here, a better solution may be to have an independent senior pharmacy professional based within the geographical area where the locum practises, or an assessor from the pharmacy regulator carry out the assessment. Still, the levels of agreement to such proposals were not overwhelming, and only around half of respondents agreed with them.

Table 4: Views of self employed and employee pharmacists on who should conduct the revalidation assessment of self employed locums

<table>
<thead>
<tr>
<th>Agree (%)</th>
<th>Neither Agree or Disagree (%)</th>
<th>Disagree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Employed Pharmacist</td>
<td>Employee Pharmacist</td>
<td>Self Employed Pharmacist</td>
</tr>
<tr>
<td>a) Self employed locums should have their assessment for revalidation conducted by an assessor from their locum agency</td>
<td>10.5</td>
<td>13.7</td>
</tr>
<tr>
<td>b) Self employed locums should have their assessment conducted by an independent senior pharmacy professional based within the geographical area in which most of their practise is performed</td>
<td>49.3</td>
<td>51.7</td>
</tr>
<tr>
<td>c) Self employed locums should have their assessment conducted by an independent senior pharmacy professional from outside the geographical area in which most of their practise is performed *</td>
<td>18.7</td>
<td>23.7</td>
</tr>
<tr>
<td>d) Self employed locums should have their assessment conducted by an assessor from the pharmacy regulator</td>
<td>45.6</td>
<td>50.5</td>
</tr>
</tbody>
</table>
One significant difference ($p = .031$) between self employed pharmacists and employee pharmacists emerged from this analysis. This was whether self employed locums should have their assessment conducted by an independent senior pharmacy professional from outside the geographical area in which most of their practise is performed (statement c). Perhaps not surprisingly, disagree responses were higher for self employed pharmacists compared to employee pharmacists (40.7% vs. 30.9%, respectively), but again, it is worth noting that high proportions among both groups of pharmacists recorded neutral responses to this item.

### 1.3.6 Who should conduct revalidation of self-employed locums: Locum pharmacists and employee pharmacists in community pharmacy

A further comparison of the same statements in the previous section was carried out between self employed locum pharmacists and all other pharmacists (including pharmacy owners, pharmacy managers, second pharmacists, relief pharmacists and non-store based pharmacists) working in the community pharmacy sector. The majority (89%) of self employed pharmacist respondents worked within community pharmacy, so a comparison of pharmacists within this sector was considered necessary. These comparisons are outlined in Table 5.

When comparing locum pharmacists with all other pharmacists working in the community pharmacy sector there are once again reasonably high levels of ambivalence amongst respondents about who should conduct the revalidation of self employed locums. There is strong agreement from both groups that self employed locums should *not* have their assessment conducted by an assessor from their locum agency. A better alternative may be to have an independent senior pharmacy professional based within the geographical area where the locum practises, or an assessor from the pharmacy regulator carry out the assessment, but still fewer than half agreed with these proposals and sizeable proportions provided neutral responses or disagreed.

Two significant differences emerged from analysing these responses – statements c and d. The differences were similar in both instances with smaller proportions of locum pharmacists agreeing with these suggestions compared with all other
community pharmacists. The proportion of neutral responses was however quite high, particularly for statement c (~42%), suggesting there was a strong element of uncertainty and/or ambivalence about these issues.

Table 5: Views of locum and employee pharmacists within community pharmacy on who should conduct the revalidation assessment of self-employed locums

<table>
<thead>
<tr>
<th>Agree (%)</th>
<th>Neither Agree or Disagree (%)</th>
<th>Disagree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum Ph’s</td>
<td>Other Ph’s</td>
<td>Locum Ph’s</td>
</tr>
<tr>
<td>a) Self employed locums should have their assessment conducted by an assessor from their locum agency</td>
<td>9.4</td>
<td>12.9</td>
</tr>
<tr>
<td>b) Self employed locums should have their assessment conducted by an independent senior pharmacy professional based within the geographical area in which most of their practice is performed</td>
<td>45.9</td>
<td>47.9</td>
</tr>
<tr>
<td>c) Self employed locums should have their assessment conducted by an independent senior pharmacy professional from outside the geographical area in which most of their practice is performed</td>
<td>16.5</td>
<td>25.4</td>
</tr>
<tr>
<td>d) Self employed locums should have their assessment conducted by an assessor from the pharmacy regulator</td>
<td>43.3</td>
<td>53.9</td>
</tr>
</tbody>
</table>

1.3.7 Who should conduct revalidation of pharmacy owners: Pharmacy owners and other pharmacists in community pharmacy

Some of the questions were concerned with who should conduct the revalidation assessment of pharmacy owners within community pharmacy. There were 40 respondents that were pharmacy owners within community pharmacy. The values given in Table 6 illustrate the levels of agreement to a number of statements relating to who should carry out this assessment. Pharmacy owners are considered along with other pharmacists within community pharmacy (including pharmacy
managers, second pharmacists, relief pharmacists, locum pharmacists and non-store based pharmacists).

Many respondents provided neutral responses to the statements suggesting there is not overwhelming support from owners themselves, or others, for any of the options provided to respondents concerning who should conduct the assessment of pharmacy owners. Statements a and c received the highest levels of agreement, though these were not the majority of respondents. According to the responses given, the option with the highest support among owners themselves appears to be for the assessment to be conducted by an independent assessor from within the geographical area in which they work, while other pharmacists favour the pharmacy regulator. Overall though, none of the small differences found between pharmacy owners and other pharmacists within community pharmacy reached statistical significance.

Table 6: Views of pharmacy owners and other pharmacists in community pharmacy on who should conduct revalidation assessment of ph. owners

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree (%)</th>
<th>Neither Agree or Disagree (%)</th>
<th>Disagree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Pharmacy owners should have their assessment conducted by an independent senior pharmacy professional based within the geographical area in which they practise</td>
<td>44.4</td>
<td>22.2</td>
<td>33.3</td>
</tr>
<tr>
<td>b) Pharmacy owners should have their assessment conducted by an independent senior pharmacy professional from outside the geographical area in which they practise</td>
<td>27.8</td>
<td>38.9</td>
<td>33.3</td>
</tr>
<tr>
<td>c) Pharmacy owners should have their assessment conducted by an assessor from the pharmacy regulator</td>
<td>40.0</td>
<td>42.9</td>
<td>17.1</td>
</tr>
</tbody>
</table>
1.4 **Summary**

1.4.1 **How competencies for revalidation could be assessed**

The majority of all respondents agreed that revalidation should be an ongoing, continuous process rather than a comprehensive assessment scheduled periodically. Perhaps not surprisingly, given its prominence in pharmacy, a substantial majority of respondents (86%) agreed that CPD should form part of the evidence for revalidation. Appraisals were another option that was well received, and evidence gathered from work colleagues and peers was also relatively popular. Such methods for assessing competencies for revalidation were viewed more favourably than other options, such as having patient feedback to contribute towards evidence of revalidation, or having information from mystery shoppers within community settings.

In general there were similar levels of agreement between pharmacists and pharmacy technicians on how competencies for revalidation could be assessed and there were similar ratios of response type. One difference that stood out in particular however was the differences between whether or not counselling skills should be observed in practice. A majority of pharmacy technicians agreed with this proposal whereas fewer pharmacists agreed.

For many of the proposals about how competencies for revalidation could be assessed there were similar ratios of response type between practitioners in community and hospital pharmacy. Nevertheless significant was that a portfolio of written evidence of good practice, and observation of counselling skills, as assessment methods for revalidation had greater appeal to pharmacists and pharmacy technicians within hospital pharmacy. The other significant finding was that community pharmacy practitioners were more supportive of the proposal to self certify that they are fit to practise and not have to undergo any form of assessment.

1.4.2 **Who should conduct the revalidation assessment**

There appeared to be an overall preference for the revalidation assessment to be conducted by the individuals’ main employer, as the highest percentages of respondents fell into this response category, although this was still only just over a
third of all respondents. This was particularly true for pharmacy technicians, where the majority (58.4%) thought their main employer would be the most appropriate assessor. Slightly over a fifth expressed no preference at all, suggesting the topic has been given little consideration, or that practitioners are simply not concerned about who is best placed to conduct revalidation assessments. The majority of self employed pharmacists disagreed that self-employed locums should have their revalidation assessment conducted by an assessor from a locum agency. Instead, the largest proportion (nearly half) of both locums, and owner pharmacists, favoured an independent pharmacist based within the geographical area where they mostly practised, or the pharmacy regulator, as the assessor of choice.

1.4.3 Importance of general issues concerning the revalidation process

Respondents considered all of the statements concerning general issues of the revalidation process important, with the vast majority deeming them very important or important. The statements covered a number of issues, such as whether they would want to be responsible for collating information / evidence to support revalidation and whether the person conducting the assessment should be trained and accredited by the regulator. Pharmacists and pharmacy technicians differed in their responses for only one of the statements, with almost all (96%) of the pharmacists but 66% of the technicians agreeing with the view that the person who conducts the revalidation assessment should be a pharmacist who has an understanding of their role. This statement also received more support from hospital pharmacists.
2 Community pharmacy stakeholder representatives’ views on appraisals and their relevance for revalidation

2.1 Introduction and method

A total of 43 semi-structured telephone interviews were carried out with a number of representatives in different organisations in the UK to gain insight into the appraisal processes that exist for pharmacists and pharmacy technicians and how they may feed into revalidation. Originally, 30 interviews were carried out between May and September 2009 as part of a project commissioned by the National Clinical Assessment Service (NCAS) that investigated issues surrounding poor performance of pharmacy staff.¹ To address the aims of this project, questions concerning appraisals and revalidation were incorporated. Ten interviews were carried out with senior members of regulatory and professional organisations, ten interviews were conducted with senior staff (e.g. superintendents; professional development managers) within eight chain pharmacies and a further seven interviews were completed with seven managers/ owners from independent community pharmacies. Finally, three interviews with senior management from three locum agencies were carried out.

When analysing the NCAS interviews, even though questions about appraisals and revalidation had been incorporated, issues emerged which had not been covered in sufficient detail to ensure data saturation had been reached. This was resolved by undertaking a second round involving an additional 13 interviews targeting key stakeholders. They were seven chain pharmacies (six being revisited; one, first time); four pharmacy technician stakeholders, including members of the Association of Pharmacy Technicians, UK (APTUK), and two with pharmacy owners from two independent pharmacies (both interviewed for the first time). This second round of interviewing was completed between February and April 2010. They allowed to gain more insight into appraisal systems within community pharmacy, and to address some further questions, such as the perceived responsibility of superintendents and pharmacy owners for the fitness to practise of their pharmacy staff, as well as
appraisals covering themselves. The topic guide can be found in Appendix 1.

Each transcript was analysed using the ‘framework’ qualitative technique which sought to unravel key themes emerging from the data. The aims of this analysis were to capture the various aspects of current appraisal methods within organisations and to identify whether these methods would fit into a revalidation framework for pharmacists and pharmacy technicians.

2.2 Identifying who is appraised/ who conducts appraisals

This section outlines the individuals that are appraised within the various organisation types and identifies those responsible for conducting the appraisals of pharmacy technicians and pharmacists holding various positions (if applicable).

2.2.1 Chain pharmacies

2.2.1.1 Pharmacy Technicians

Appraisal systems were in place for pharmacy technicians within eight of the nine chain pharmacies interviewed. Interviewees from six of the eight multiples that had these appraisals in place, stated that the pharmacy manager would be the one responsible for conducting the appraisals. An interviewee from Employer 6 reported that a team leader (who may not be a pharmacist) may also conduct the appraisal of pharmacy technicians in some cases. The individual responsible for conducting the appraisal of pharmacy technicians within Employer 8 was not reported by the interviewees as they were only interviewed for the NCAS project which did not probe such questions.

2.2.1.2 Pharmacists

Appraisal systems were in place for pharmacists ranging in position from branch pharmacists to superintendent pharmacists within eight of the nine chain pharmacies interviewed. These appraisals would be conducted by the relevant line manager of
the individual who may or may not be a pharmacist. The interviewee from Employer 9 reported that an official system of appraising pharmacists positioned below area managers were not in place; these appraisals would be conducted by the regional managers. The interviewee from Employer 9 was not familiar with the appraisal processes that existed for those positioned above the area manager.

2.2.1.3 Organisational infrastructure of pharmacist positions

The hierarchy of the various positions of pharmacists involved in the appraisal process as well as the names / labels given to pharmacy management positions (e.g. pharmacy manager; area manager) within the chain pharmacies were not consistent but there were some similar features between them. As the infrastructures between the chain pharmacies were different, there were various members of staff responsible for the appraisals of different pharmacists, depending on their position within the organisation. In general, the appraisals of pharmacists and more senior pharmacy management staff were carried out by their line manager, i.e. the individual above them in the organisational hierarchy of management (a top-down process).

A few examples of the hierarchy of pharmacy management lines will be explained in order to elucidate the general management framework in place within some chain pharmacies. For instance, within Employer 1 there are pharmacists within the pharmacy, but there is no pharmacy manager. An ‘ambient team leader’ would be the line manager for the pharmacy, dealing with the appraisals of pharmacy staff, and they would report to the general store manager. ‘Coaches’ – which are basically equivalent to area managers – were also in place. They would look after 25-40 pharmacies but they mainly drive the business side of the pharmacy, ensuring the pharmacy is meeting its targets. The coaches may or may not be pharmacists, but the interviewee from Employer 1 said this position was moving towards being filled with pharmacists as standard. A divisional operations manager is positioned above the pharmacy coaches in the hierarchy and would be responsible for appraising them. They may or may not be a pharmacist; an interviewee from Employer 1 pointed out that the divisional operations manager currently is a pharmacist but did not used to be. The divisional operations manager would report into the retail side of the business to more senior business executives. In the head office, representing
pharmacy would be the superintendent pharmacist and the pharmacy buyer, who may or may not be a pharmacist. The superintendent pharmacist’s appraisal would be conducted by their line manager: the category director for optical and pharmacy, who is not a pharmacist. A comment made by an interviewee from Employer 1 illustrates the changes to the pharmacy infrastructure over the years:

*When I was in [name removed] about twenty years ago it was all pharmacist managers, but now there’s often non-pharmacist line managers.* (Employer 1a)

Other systems of management were in place within other chain pharmacies such as Employer 7. Within this chain pharmacy there were two types of pharmacist in place within a pharmacy: a pharmacy branch manager and a relief manager, who would cover for various branch managers. Above this would be regional development managers (RDMs) who would appraise up to 35 pharmacists (branch managers and relief managers) from approximately 25 branches. These RDMs ‘are not necessarily pharmacists’ according to an interviewee from Employer 7, nor are the four divisional operations managers that the RDMs report to which cover the organisation’s pharmacy operations across the UK. The divisional operations managers would report into an operations director who would sit on the executive board, and does not need to be a pharmacist. The superintendent’s office is a separate function that provides a support role to pharmacists and managers in the business. The superintendent is appraised by the managing director, who happens to be a pharmacist, but this is not mandatory. An interviewee from Employer 7 pointed out that possessing a formal pharmacy qualification and thus being a pharmacist is not a necessity for their job role:

*We don’t believe it’s a necessity for, for our area managers to have pharmacy, a pharmacy qualification ’cos at the end of the day we’ve got, we employ people that, that already know that stuff.* (Employer 7b)

It is also worth discussing the pharmacy infrastructure within a third chain pharmacy – one of the larger organisations – to highlight some of the similarities and differences between its management set up and that of other chain pharmacies. Employer 6 had two lines of management, one for operations (the more retail side of the business) and a parallel line for pharmacy. The operations management line is structured as follows. Within a pharmacy there would be a ‘responsible pharmacist’
who would essentially be the one in charge of the pharmacy (i.e. pharmacy manager) with an additional pharmacist present in the pharmacy if needed, as is the case in busier / larger stores. This supporting pharmacist would be appraised by the pharmacy manager, and the pharmacy manager would be appraised by the store manager, who may or may not be a pharmacist. This store manager would report into an area manager who once again may or may not be a pharmacist. Above the area managers are regional managers, who may or may not be pharmacists, which act as the line managers to a number of area managers. The regional managers report into one of five divisional directors, three of which are pharmacists. These divisional directors report to a stores director that sits on the executive board and who is not a pharmacist. The stores director is appraised by the chief executive of the organisation.

The pharmacy management line is structured as follows. The supporting pharmacist and responsible pharmacist would be overseen by an area pharmacy manager, and this area pharmacy manager would then report to a regional pharmacy manager. Both of these roles are filled with pharmacists. The regional pharmacy manager would report to an operational-line regional manager (mentioned above). In addition to this there is a divisional pharmacy manager, though this individual does not have the line accountability for the regional pharmacy manager, instead they deal with the general pharmacy professional strategy and clinical governance within their division. The divisional managers report (through a so-called ‘dotted’ line) into the superintendent, and also to one of the five divisional directors from the operations line. The superintendent would be appraised by the director of pharmacy in retail who is a pharmacist. The appraisals of pharmacy managers are carried out by the operations line, but they are supported by the parallel pharmacy line. For example, if a pharmacy manager is being appraised by a store manager that is not a pharmacist than they will generally gain insight from an area pharmacy manager to help with the appraisal process.

In some of the chain pharmacies that were interviewed (Employers 1, 2 and 5), the appraisals of second (support) pharmacists and / or pharmacy branch managers were conducted by line managers who were most often non-pharmacists. It was
generally the case that the general store manager would be responsible for conducting the appraisals of the branch pharmacists.

…the store managers are the people who will…are the line managers of the pharmacists…and they will conduct appraisals and the appraisals that we use are a personal development review process… (Employer 2, int. 2)

Within another chain pharmacy (Employer 3) an interviewee stated that relief pharmacists (if in place) and the pharmacy manager would be appraised by an area support pharmacist who would conduct the appraisals of pharmacists within approximately ten branches including their own. Moving higher up the management hierarchy is the deputy superintendent pharmacist, who reports to the superintendent for their appraisal. Finally, the superintendent pharmacist would report to the managing director for their appraisal. The infrastructure in place within Employer 4 and Employer 8 was not as explicit. It was pointed out that line managers of subordinate staff were in charge of conducting the appraisals, so this may or may not have been a practising pharmacist.

Locum Pharmacists did not undergo a formal appraisal or performance review process within any of the chain pharmacies that were interviewed. The general consensus was that they were not official members of staff and therefore they would not be covered in such monitoring; an explanation may be to do with employment issues:

The locum ones, you’re not allowed to appraise locums because that classes them down for employee and gives you a tax and NI issue. (Employer 7a)

Another explanation for not conducting formal appraisals with locums was expressed by another interviewee from Employer 4:

…locum pharmacists are probably best reviewed by the people that work with them or tend to be reviewed by the people that work with them which tends to be the dispensers and the technicians within the pharmacy. And I think they, they sort of ultimately will say, “Yes we’ll have that one back” or, “No we won’t have that one back” you know so, so it’s not you know it’s not the best way but no they don’t…we don’t do anything with locum pharmacists at all. (Employer 4)
Appraisals of the most senior pharmacist within the chain pharmacies, the superintendent, were routinely carried out but it was often the case that a non-pharmacist would conduct it. Perhaps this is not surprising based on the general infrastructures within the organisation, i.e. a high propensity for non-pharmacists to be line managers in the pharmacy-side of the business’s infrastructure.

It was apparent from the pharmacy infrastructures in place within the chain pharmacies that there were no strict rules that require pharmacists to be appraised by pharmacists. This suggests that many of the tasks pharmacists, particularly those in patient-facing roles, carry out related to fitness to practise go unassessed in an appraisal.

2.2.2 Independent pharmacies

2.2.2.1 Pharmacy Technicians

Independents 1, 3, 8 and 9 had an appraisal system in place for pharmacy technicians. Within independents 1, 3 and 9, the pharmacy manager or owner would be in charge of conducting the appraisal. Within Independent 8, the HR manager – who happens to be a qualified technician – carries out the appraisals. An appraisal system was not in place for pharmacy technicians within the other independent pharmacies.

2.2.2.2 Pharmacists

Formal appraisals for pharmacists within the nine independent pharmacies that were interviewed were not in place. The interviewee of one independent pharmacy (Independent 6) reported that they were planning on implementing an annual appraisal process for all staff (including pharmacists and pharmacy technicians) in the near future though nothing was in place at the time of the interview (September, 2009). Another (Independent 7) stated that appraisals were done more on an ‘ad-hoc’ basis, i.e. they took a reactive approach to monitoring performance issues. Independent 4 pointed out that there was only an appraisal system in place for their pre-registration pharmacist and this appraisal would be an overall discussion
between the pharmacy manager and pre-registration student about their strengths and weakness and performance overall.

An issue with regards to monitoring of pharmacists (including locums) within independent pharmacies was raised, and illustrated the possible ‘freedom’ these individuals have within independent pharmacies:

…the pharmacists don’t have line managers as such because they work in a shop by themselves so no one is sort of sitting, watching them. (Independent 3)

2.2.3 Locum agencies

The interviewees from the three locum agencies explained that they normally undertake background checks of those who register with them and ensure their clients are up to date with professional registration; but appraisals were not part of their remit. They have no systematic measures in place to appraise pharmacists or pharmacy technicians on any issues concerning fitness to practise and revalidation. One professional body highlighted some difficulties that locum agencies may face with appraisals or dealing with poor performance:

They’re not equipped for it, you know, you got to understand that some of these, these agencies have people who are, a) they’re not pharmacists, b) they’ve got no, I mean they’re basically co-ordinators and administrators, yes, and if they – because a locum starts upsetting them or because they may get unreasonable feedback – if they start to decide that they’re going to refer it then it will be totally, you know, not only will it be very subjective but it would be probably an uninformed and very subjective way of dealing with things. Yes, I think it’s an absolute recipe for disaster. I think the other thing is, I think many Locum agencies wouldn’t want to do it quite frankly because, you know, all they’re about is deciding who wants, who’s desperate for pharmacists and how many desperate pharmacists can I get who want work and put them together, you know, and some Locum agencies have absolutely no quality control processes going through them at all and you can’t regulate for that quite frankly… (Organisation 6).

Locum Agency 3 commented about the difficulty of an appraisal process within their work:

…first of all with appraisals you do have to be face to face…you do have to have had experience, first hand experience to their work and I think it’s a joint thing is an appraisal…you know the locum has. Also to gather or the locum should gather information of, of you know of what they’ve excelled at, what they are good at and
The fact that locum pharmacists may not undergo an appraisal with their agency, or indeed their employer (e.g. one of the chain / independent pharmacies interviewed) suggests these pharmacists may lack appropriate monitoring which may have implications for revalidation. As the locum agencies that were interviewed did not conduct formal appraisals with the pharmacists they deal with they will not be considered in other sections of the report that are pertinent to the appraisal process in place.

2.3 How often appraisals are conducted

This section reviews the frequency in which the appraisals of pharmacy technicians and pharmacists were reported to be conducted within the chain and independent pharmacies interviewed.

2.3.1 Chain pharmacies

Interviewees representing eight of the nine chain pharmacies said there was an appraisal processes with pharmacy technicians and pharmacists on a, at least, annual basis. Interim reviews were also done in some of these organisations, generally on a quarterly or six-monthly (per annum) basis. Employer 9 did not have a formal appraisal system in place for pharmacy technicians though appraisals were in place for area managers which took place on an annual basis.

2.3.2 Independent pharmacies

2.3.2.1 Pharmacy technicians

Pharmacy technicians were appraised by management in some instances (e.g. Independent 1, 3, 8 and 9). These would generally occur on an annual basis, sometimes being reviewed in six months.
2.3.2.2 Pharmacists

Formal appraisal systems were not in place for pharmacists within the independent pharmacies interviewed.

2.4 Areas covered in the appraisal process

Interviewees were asked to describe what was covered in an appraisal of pharmacy technicians and pharmacists within their organisation. Interviewees were asked to discuss a range of topics that may have been reviewed during an appraisal (business, professional and/or clinical skills) to see if this could lend itself to a revalidation assessment in the future.

2.4.1 Chain Pharmacies

2.4.1.1 Pharmacy technicians

The appraisals of pharmacy technicians within chain pharmacies tended to be focused on the performance of the individual and contribution to the overall performance of the pharmacy store. Appraisals of pharmacy technicians also appeared to be similar to that of other members of staff (such as counter assistants) in the pharmacy, and did not address fitness to practise issues, even though it was generally the pharmacy manager carrying out these appraisals.

For instance, an interviewee from Employer 1 stated that pharmacy technicians receive a basic appraisal but it is not as thorough an appraisal as pharmacists.

They [pharmacy technicians] get a very basic appraisal along with other colleagues…but not a thorough one like pharmacists get.  (Employer 1a, int.2)

This interviewee went on to say that pharmacy technicians are considered more similar to other colleagues than pharmacists and this influences the way in which they are appraised:
[the appraisal is] still very much as any other colleague in the store as opposed to a pharmacist. I think once they become registered and we, we see them in the same way...then they will get different appraisals which will be more closely lined to pharmacists than to normal colleagues...but currently our view is that they’re more like colleagues than pharmacists. (Employer 1a, int.2)

In a similar way, an interviewee from Employer 3 suggested the appraisals for pharmacy technicians within their organisation were comparable to other staff members:

… we run a standard appraisal for all our staff and actually it’s just…it’s just that standard appraisal, and it covers timekeeping and working to the job description and sort of general set of twenty four questions. (Employer 3, int.2)

Some interviewees commented on the issues that were covered for an appraisal of a pharmacy technician within their organisation, which seemed to be focused on general performance, in a business context:

They’re very wide based. They’re really an opportunity for the individual to discuss any issues that they specifically…but will obviously be focused around the performance of the individual so it’s, it’s more about getting them to sort of talk about what they think is important and then overlaying that with what the pharmacist or pharmacy manager will, will want to talk about so there’s a bit more of a sort of the you-me agree type situation. (Employer 2, int. 2)

[the appraisals are] about the contribution of the individual and how they wish to contribute and how they can contribute using their own strengths you know. (Employer 2, int. 2, p.1)

[the appraisal] wouldn’t be a…it’s not a conversation about clinical capability…or professional capability it would be a, it would be a conversation that’s probably more, more easily associated with a business context. (Employer 6b, int.2)

Discussing the objectives met throughout the year during an appraisal – synonymous with performance – seemed integral to the appraisal process in some cases, for example:

…so it’s [the appraisal] really a summary of…you were set objectives for 2009, have you met those objectives? Have you exceeded them? And what development do you need going forward…it’s a very positive process our appraisal process. (Employer 7b)
[the appraisal] would be a review of their performance against a set series of objectives. […] and those objectives would be…so the same approach as it would be for our pharmacists as well actually. So a series of objectives would be agreed at the start of the year, they would have a review at least twice through the year but normally four times so we aim for a quarterly review. So it’s…we’d like to call it the ‘great conversation’ that they would have, so it’s a discussion about how they are performing against their objectives and also about how they’re delivering against those so it’s not just what they’ve delivered but how they’re delivering it. So there’d inevitably be a conversation around customer care, there’d be conversations around their contribution to the performance targets and that particular area of the business…so it’s, it’s quite a broad conversational piece. (Employer 6b, int.2)

One pharmacy technician stakeholder provided some further information about the appraisal process within the community pharmacy they’re employed in:

Within [name removed] certainly, we have an appraisal every year … that’s just an appraisal of your performance within your work place. They look at you’re…yeah…how you’re performing within the business, they look at career progression, they sort of talk of your weaknesses and your strengths…you know, ask if there’s anything that they can do to help improve your performance if you weren’t performing as they want you to… (Pharmacy Technician Stakeholder 2)

There was a noticeable absence of assessing the fitness to practise elements of the job from a number of interviews. When an interviewee from Employer 3 was asked if the appraisal covered any professional and clinical competencies they stated:

It doesn’t no, I think that’s clear, but what…the question you’re asking, it is very much about it’s a general performance measure rather than a specific performance measure, based on their clinical role. (Employer 3, int. 2)

When another interviewee was asked about the appraisals of pharmacy technicians and whether or not clinical or professional issues came up the interviewee replied:

No, they’re more about your individual performance within the workplace. (Pharmacy Technician Stakeholder 2)

Some interviewees did however report that there were some elements of professional and clinical competencies examined in an appraisal in addition to business-related performance. This was exemplified by one interviewee:

Well in essence it [the appraisal] would be around a business plan of the pharmacy, so…whatever the KPI’s [key performance indicators] for that individual pharmacy are in terms of the volume, growth, in terms of error rates and standards, in terms of prescription collection service, and so on and so forth. […] I think, I mean, clearly
there are business KPI’s…but then there are issues around the professional aspects of the business, such as, you know, delivery of the standard operating procedures and making sure that they are appropriate for that individual pharmacy. Delivery of pharmacy services in terms of development of, you know, things that are appropriate for that particular pharmacy and that would go against both the pharmacy or the pharmacists, including the pharmacy manager and the technicians. So, it’s a…a sort of, yes, there’s a business focus, but there’s also a clinical focus. (Employer 5b)

The general consensus from the interviewees was that the appraisals of pharmacy technicians were around performance that contributed to the overall performance of the business, although this may involve clinical services. However, an appraisal was not generally an assessment of a pharmacy technician’s fitness to practise.

2.4.1.2 Pharmacists

As discussed, many ‘chain’ pharmacists are in positions that extend beyond the in-store, patient-facing pharmacists (e.g. regional managers; divisional managers). In addition, many of these management positions were filled by non-pharmacists. Regardless of whether these individuals were pharmacists or not there appeared to be a strong business focus on the appraisal as their job role was managerial in nature. This business-oriented approach to appraisals was present throughout the appraisal process for most positions within the chain pharmacies that were interviewed, even for those pharmacists who were more patient-facing (e.g. support pharmacist; pharmacy manager). Some examples of this strong business focus of appraisals were highlighted in a number of interviews:

I would say our appraisal system is probably more business orientated… from, you know, all the way through. We do give our pharmacists an extra day for providing evidence that they have recorded CPD, and in so doing have clocked up, sort of, thirty hours of continuing education…and I would say that is our only appraisal of their clinical abilities, if you like. (Employer 3, int. 2)

So the ones [pharmacy managers] at the bottom yes are certainly managed but, but it’s probably against our key performance indicators, you know, so there are a whole set of indicators within a pack that they hold which are things that will certainly not relate to clinical...because clinical will only go down on their own development plan. So it will be around you know targets with prescription numbers or…cash through the tills. (Employer 4)

…and so we’re very interested in the number of measurements and parameters around that [customer care system] and one of those key things is, is how they are working in order to provide customer care. So they might have a particular target set around
the number of consultations that they undertake, around the...perhaps for the management services around the level of additional professional services they're providing in a location so how many advanced or enhanced services in England or Wales they might be providing. (Employer 6b, int.1)

These [performance reviews] would be basically business targets and also development objectives etcetera, but primarily business targets across the whole range of business you know professional, operational, commercial, people leadership. (Employer 6a, p.2)

The same interviewee (Employer 6a) also appreciated the pressures faced by pharmacists with such targets in place that could be monitored quite regularly:

Well I think stress will come into it because if things like...if you have a target for MURs because of our reporting we, we can now you know day by day, week by week of how people are performing when they get to the target. And then some...you get some line managers who will use sort of name and shame tactics or email kind of name and shame tactics etc. And that will undoubtedly cause abnormal stress and pressure. (Employer 6a)

Some interviewees pointed out the even stronger business / management focus of appraisals for more senior pharmacy positions:

...as we go further up the chain, then clearly, the financials, if you can call them the financials, become more important...so the business commercial objectives probably become more important. (Employer 5b)

Within Employer 9 (where trials of appraising pharmacy managers has only recently begun), appraisals for more senior pharmacists (e.g. area managers) did occur, but, as the interviewer noted, these were highly business focused as within other organisations:

It's similar...it's very obviously with it being the area manager role it's very business focussed [...]and basically justifying what I've done over the past quarter, reviewing the targets that [the line manager] set me the previous quarter. (Employer 9)

As one professional body stated, appraisals may focus largely on “commercial drivers” and pay less attention to professional performance:

There are appraisal systems in many primary care community pharmacies, but if you look at an employer, an appraisal system might be based entirely on commercial drivers. You know, how, how many prescriptions do you do in a month, you know, what’s the efficiency of the business, what’s your out of stocks, what’s the average
Evidence such as this suggests that appraisals in larger organisations do not pay much attention to clinical and professional competencies of their pharmacists. Clinical competencies, for example, were seen by many interviewees as skills that a pharmacist should come equipped with and pharmacists should not require support from the organisation with these skills. Some interviewees did however explain how these issues may be covered during an appraisal. An interviewee from Employer 1 pointed out that they have ‘key results areas’ to set standards for both business and professional issues:

...we’ve set them as standard at the beginning of the year and work towards those. So they’re both on professional level and a business level. It’s also about services you bring into the pharmacy, percentage of owings and dispensing errors and all those kind of things so if somebody was underperforming it should be highlighted during the half yearly reviews or the, or the appraisal system. (Employer 1b)

Likewise an interviewee from Employer 2 commented that their appraisals (performance development reviews) covered not only business targets, but some professional issues such as an individual’s behaviour and attitude. Another interviewee representing Employer 3 explained how the appraisal system covered performance in a ‘wider sense’, and considered issues such as communication skills:

...the appraisal itself doesn’t particularly reflect the, the target of performance I think you’re saying you know it, it is much more about performance in a, in a wider sense of management of, of how people are dealing with certain issues. You know it does probably deal with things like communication, written and oral communication by feeding back issues and that type of thing… (Employer 3, int.1)

Interviewees from Employer 4, 7 and 6 also commented on the inclusion of professional issues in appraisals and monitoring. For example, an interviewee from Employer 7 commented:

...if the KPI that you’re looking at in a, in a business you had a branch where everything was obviously red then that would indicate that you know some type of, of that person’s performance was underperforming. Clearly some things that we’re expecting our pharmacists to do are professional, some things are operational. So again it’s separating out an operational thing that you’re not doing right or is it to do with your, your ability as a pharmacist, again we have to be clear. You know if it’s
just that they, they don't, they don't do a managerial task then again that's separate to you know actually you're a risk to the public because of your, you know professional poor performance. (Employer 7a)

Some interviewees offered an explanation of why fitness to practise elements of pharmacy such as clinical and professional skills were not considered:

If we’re looking at number targets in terms of clinical issues we, we don’t measure very much because we tend to assume that every pharmacist comes as a fully trained pharmacist already and doesn’t need any more support from us on that. (Employer 1a, int. 1)

So when we employ the pharmacists we employ them knowing that they’re pharmacists…and we don’t try and teach them pharmacy. But we do teach them how we work in [name removed] as a pharmacy. (Employer 1a, int.2)

We don’t believe it’s a necessity for, for our area managers to have pharmacy, a pharmacy qualification ‘cos at the end of the day we’ve got, we employ people that, that already know that stuff […] So the reporting structure doesn’t rely on having a, a, a Pharmacist at the top of it, you know by chance our, our Managing Director is a Pharmacist but that’s, that’s you know that’s really by chance… (Employer 7b)

When one interviewee was asked if clinical competence or any other professional related issues was considered during an appraisal, they responded:

No we wouldn’t be assessing [it]…so we will take, take the fact that that individual appears on the register their name appears on the register means that they are competent to practice as a pharmacist. What we won’t be doing is supplementing that by our own assessment of their clinical capability… (Employer 6b, int. 2)

Clinical skills, e.g., in a specific area, may only be assessed if a new service were to emerge that the pharmacist would need training in:

I suppose the simple one to quote would be something like seasonal influenza vaccination. In order to be able to provide that service we have provided training, an individual would go through that training and be assessed by an assessor and their competence to be able to provide that service would then be confirmed to my office before they were then able to commence provisional like service to, to the public. (Employer 6b, int. 2)

…but yeah clinically, clinically wise where we do services that are new, we would always go out and train them, the team as well as the pharmacist. (Employer 7b)
Issues of poor practice would rely more heavily on customer complaints or staff feedback. When an interviewee from Employer 4 was asked how they would pick up if somebody was underperforming clinically, they responded in a way that demonstrated the review process was not sufficient to analyze clinical issues, and therefore did not cover some important practising issues:

…our regionals would certainly not go in and review their clinical performance basically….it [identifying poor performance] would be difficult, you, you would possibly pick it up because you would get a…you might be getting complaints…

(Employer 4)

Some interesting comments were made with regards to superintendents’ appraisals being done by non-pharmacists. For example, an interviewee from Employer 5 said that the senior training director – who conducts the appraisal of the superintendent – is perfectly capable of appraising the superintendent even though they are not a pharmacist. Moreover they stated:

…I mean, I think at my level [as superintendent] it is much more about management and management ability and frankly about delivery of performance targets and so on and so forth. (Employer 5b)

Again, similar views on the parameters of the superintendent’s appraisal were shared by an interviewee from another chain pharmacy:

…at that level you’re talking really quite senior people […] it’s all about managing you know what risks…how many cases, complaints and how many inspector issues we have. (Employer 7b)

It was clear from the interviews with the chain pharmacies that there was a strong focus on the business-related performance in an appraisal. Examining clinical and/or professional competencies was not something that was assessed heavily during an appraisal. The analysis of the interviews also highlights that the performance of line management positions in the pharmacy infrastructure is not really judged on pertinent pharmacy-related skills, i.e. fitness to practise, but rather more general management/business performance. This may be why it is not considered essential for these positions to be filled by pharmacists. Another common feature of the appraisal systems within chain pharmacies was that the higher up the pharmacy infrastructure an individual progresses, the more business focused their job became.
Regardless of whether the individuals senior in this organisation were pharmacists or not, they were generally appraised on business-related targets than aspects of pharmacy practice. Pharmacists in more senior pharmacy-related positions within the business would often be appraised by a non-pharmacist, which was considered acceptable as individuals in senior positions dealt with more managerial tasks than clinical-related tasks which are required in a pharmacy. If there was no scrutiny in place for assessing fitness to practise in the appraisals of senior pharmacists, it is unlikely such a framework for assessing the fitness to practise of branch-based pharmacists would be in place.

2.4.1.3 Appraisal documentation

Interviewees from employers 2, 6 and 7 agreed to provide the research team with appraisal documentation. Other interviewees either did not feel comfortable with sharing this information with the research team or did not respond to written requests asking for this. The three appraisal documents that were obtained were analysed and shared very similar features. There was a strong focus on objective setting for meeting corporate targets in all three appraisal documents. For example, in the documentation from Employer 2 there was a table with the heading “Corporate target” with subsequent column headings requesting information about how individuals will know when they have achieved such objectives. The appraisal document from Employer 6 had typical statements of business objectives provided in a table within the document such as “to drive great customer care I will…”. In the appraisal document (for pharmacy branch managers) provided by the interviewee from Employer 7 there were the headings “key performance indicators” (KPIs) alongside “key measures” and “target” listed in a table with space for comments. A number of KPIs such as “OTC sales” and “Customer Service” were provided with key measures explaining how the KPIs could be achieved, and how targets were expected to be met by the individual. The appraisal document for “branch colleagues” was similar though it did not contain a section about KPIs. It did however have a similar section to the branch managers’ appraisal document: appraisees were to provide comments about performance and its relation to competencies such as “confidence” and “customer focus”; appraisees give evidence to show how the competencies could affect their performance.
In addition to the strong business-oriented theme present in all three appraisal documents, there was also a focus on personal development, though this appeared quite open without as many stipulations. There were tables provided in all of the available appraisal documents which allowed the appraisee to consider their own personal development plans and targets. Employer 6 had a section devoted specifically to career development which allowed appraisees to consider their job prospects and career ambitions within the organisation. Other organisations may have comparable appraisal forms as the three that were examined as the areas covered within the appraisal forms of these three organisations shared many similarities.

2.4.1.4 Routine monitoring

Some of the ongoing checks on pharmacy staff performance that could occur outside of the appraisal were discussed in some of the interviews. Examples of monitoring in place included measuring store performance through colour-coded schemes which rate store performances according to a colour (e.g. red is very poor) and weekly and monthly score cards (Employer 1 and 3, respectively). These methods measured both business and professional issues (such as clinical governance), but appeared to be more focused on the business side. An excerpt from one interview illustrates some of the business target pressures faced by pharmacists:

*Each week we send out what we call a score card which picks up sales, prescription items, MUR services, all, all the KPIs in terms of numbers, that is shared with every store, so every store sees what everyone else is doing and how they’re doing it and the pharmacists then have to try and get to that level with support from, from you know from us and from the store. (Employer 1a int.1)*

With regards to identifying performance-related concerns, the interviewee representing Employer 2 stated:

*We have something that we use which is, is basically a performance monitoring and management tool called a score card and on that score card there are twelve parameters which stretch from everything…the range of basic sales right the way across to scores on the professional audits. So that’s a very live document and that’s updated on a periodic basis so four weekly ‘cos we tend to work in four week portions in, in [name removed] and that information is shared with the individual*
pharmacy managers, with the operation managers so they can see it as a, as a whole grouping. And of course centrally we have an overall view of the picture. So that will and we basically on that use a simple red, green, amber scoring. (Employer 2 int.1)

There may be the assumption that pharmacists are performing well until something goes wrong; proactive monitoring may be considered unnecessary:

So as I say from a clinical governance perspective you need to say, “Is that person performing well as a pharmacist?” and I guess the reality would be, and this is just an opinion, is that people are assumed they are until something goes wrong… (Employer 5a)

Professional issues were examined in some instances. For example, due diligence checks overseen by the area manager – ensuring things such as patient medication records (PMRs) were in order – occurred four times per year (Employer 5). An interviewee from Employer 2 spoke of audits covering professionalism / clinical governance that took place at least twice yearly – being undertaken by the operations manager. This could be used as a way to gauge store performances and the members of staff who contributed to it.

Line management had responsibility for identifying business and professional issues as well if it arose. Customer complaints could also be used as a means of identifying performance problems with pharmacists as was pointed out by the majority of the interviewees. Some interviewees also pointed out that issues of fitness to practise should be resolved outside of appraisals, and should not wait until an appraisal to deal with them:

I think the thing to add to that would be that obviously appraisals happen on an annual basis with an interim review and we wouldn’t possibly leave it for an appraisal to identify poor performance and bring it to the attention of the individual so they’re a great tool for building and bringing stuff together and documenting. (Employer 8)

With regards to errors being made by, for example, pharmacy technicians during the year:

…[errors] would be picked up in appraisal but I would hope it wouldn’t be, we wouldn’t wait until the appraisal came round, so by that I mean that if we’ve got concerns throughout the year…that we’re picking them up throughout the year and at the appraisal we’re telling them whether we’ve got concerns that are ongoing or
whether they've improved or not...the appraisals only happen once a year you see, so they're, they're really quite a one off event...if we had concerns on a clinical basis, we certainly wouldn't be waiting until the appraisal before we raised them. (Employer 7b)

If there's a dispensing error or a customer complaint and it highlights an issue whether somebody isn't as smart clinically as he should be, then I'll discuss that with another senior pharmacist that works within the company, actually works in the store...or we have a group of what's called the Professional Development Group...there are nine pharmacists who come into [name removed], probably every four months or so to go through what's going on and they use them as a sounding board, and they probably put it to them to consider but I've not done that in the past, there's never been an issue for us. (Employer 1a, int.2)

Routine monitoring of the performance of pharmacy technicians and pharmacists was common amongst the chain pharmacies interviewed, but again, these did not appear to tap into fitness to practise issues to the extent likely to be required for revalidation.

2.4.2 Independent Pharmacies

2.4.2.1 Pharmacy technicians

Pharmacy technicians were appraised by management in some instances (Independent 1, 3, 8 and 9), though this appraisal did not appear to be a critical evaluation of the professional aspects of their position, but rather an overview of their job role and how their performance compared to expectations with the role:

It's [the appraisal] specific to the person's role and it's what they do and, you know, are they doing what we want or could we improve what they're doing. It's more, it's a two-way process, how does the person feel about how they're doing and then if we wanted them to do something a little different, maybe make a few suggestions. (Independent 3).

When asked what would be covered in pharmacy technician appraisals, the interviewee from Independent 8 reported they there would be a review of:

...their overall performance...how they, how they think things are going, any training needs that they think they've identified that we can, that we can address. And obviously any training that we've, that we've done we try and get feedback of how useful that's been as well. And sort of more questions what, what things they would like to do in the next year whether they want more responsibility, they're happy with what they've got or what have you. Their performance over the year how they've,
how they’ve worked. You know if they’ve been audited, you know if they’ve had arguments with customers or all the sort of things you would expect…sales and that sort of thing but its difficult when there’s as many people working here that attribute anything to one individual. (Independent 8)

An interviewee from Independent 7 said appraisals were done on an ‘ad hoc’ basis and an interviewee from Independent 6 said they were hoping to bring in an appraisal system for staff in the near future. The interviewee from Independent 5 said that, although there wasn’t an appraisal in place, feedback was given about how staff perform and interact with colleagues and customers:

We like to give feedback on a regular basis, but we don’t do an official you know performance management or anything. […] you give feedback on things like you know how are the staff kind of, interact with each other, and you know […] and anybody else working in pharmacy, obviously how they interact with the, with the customers ‘cos you know, they’re, they’re the income stream, you’ve got to, you’ve gotta treat them well […] (Independent 5)

2.4.2.2 Pharmacists

No formal appraisal systems were in place for pharmacists within the nine independent pharmacies interviewed. However, there were comments by some interviewees about some of the feedback which pharmacists may receive:

I don’t do formal appraisal I just do kind of one-to-ones with [pharmacists] during the year. […] we tend probably to sit down together more in a formal situation because we have four managers meetings a year. The sort of things that come up in the meetings are training needs…for example you might be required to be accredited to do certain services particularly in England, for example MURs, emergency or oral contraception. (Independent 8)

…some of the things which, which appear to sort of, to go wrong then we, we provide feedback for them to look at you know what, what that is. We sort of provide general feedback about things which go wrong in a general sense so that…you know so they pick, pick up and learn from you know other things…which I think is probably as much as we can you know sort of do with regard…you know with regard to sort of issues which arise here. (Independent 9)

…we ask all the staff on a regular basis, feedback on, on the pharmacists and that’s which, it tends to be kind of ad hoc so it’s you know, if, if we have a pharmacist a locum who comes in and you know, they haven’t worked in the pharmacy before will, we’ll ask quite a lot of questions after they’ve first been there…to find out how, how they’ve gone and then there’ll be kind of periodically, after that with the, with the regular locums that we have…obviously we, we also bear in mind things like the patient satisfaction questionnaire that we, that we do every year and any feedback
that we get from you know, from patients and members of the public you know, any, any, any criticisms that, that’s made of any of the staff obviously is dealt with you know, depending on the nature of the, of the, of the problem. (Independent 5)

Well you give feedback on things like you know how are the staff kind of, interact with each other, and you know, and anybody else working in pharmacy, obviously how they interact with the, with the customers ‘cos you know, they’re the income stream, you’ve got to, treat them well…and you [also give feedback on] how efficient they are, you know, do they, you know if we, ask them to work within a standard operating procedure that they, you know, they read signs, understand and follow it…and also they give us feedback if, you know, if there is any problems and issues. (Independent 5)

Although a formal appraisal system was not in place within the independent pharmacies there were still attempts made to provide feedback to pharmacists when possible. However, such feedback would not necessarily address fitness to practise issues and may only emerge if problems were encountered. Routine monitoring of pharmacists and pharmacy technicians generally took the form of feedback provided by the pharmacy manager/owner as discussed.

2.5 Appraisal methods and their use for revalidation

This section discusses the current appraisal systems in place for chain pharmacies and their usefulness for clinical / fitness to practise issues which are pertinent for revalidation.

2.5.1 Chain Pharmacies

2.5.1.1 Pharmacy technicians
When questioned whether the appraisal systems in place were a useful system in assessing fitness to practise and revalidation the general consensus was ‘no’, or at best, that it contributed towards measuring fitness to practise only modestly. Some interviews commented that their current organisation’s methods only went part of the way and thus would need developing. For example:

They will be part of the evidence portfolio I don’t think they can be the total evidence portfolio in any way, shape or form. Because I think you’ve got to…when in any
evidence portfolio, you will have to include ‘what have you done to keep yourself up to date?’ in terms of CPD, etc, etc…which although is covered in the appraisal, you don’t get the…you don’t get the detail of what’s been done…in any appraisal documentation…so, you know, in…in my view re-validation has got to have a portfolio of evidence…of which, you know, delivery of the appraisal objectives will help to form part of that portfolio of evidence. (Employer 5b)

…I think there’s, there’s probably quite a lot of work that would need to be done around introducing the correct and appropriate measures of professional performance and the ability and the coaching of the person…ultimately assessing that…as well that, that would need to change. (Employer 6b)

As the appraisal did not go into too much detail with regards to professional and / or clinical areas of the job roles it is not surprising that appraisals of pharmacy technicians within chain pharmacies were not seen to be appropriate for revalidation. Most interviewees thought revalidation would have to be more comprehensive than their organisation’s current appraisal system.

2.5.1.2 Pharmacists

As with the appraisal system in place for pharmacy technicians, the appraisal system for pharmacists was not considered very useful for revalidating pharmacists:

The current appraisal system we’ve got is…it wouldn’t necessarily address all the areas that could perhaps come under fitness to practise. It…I think what it provides us is something that you know if, if that person’s appraisal meets our requirements and then we can, we can use that as a, as a benchmark if you like if someone’s performance then alters. (Employer 3, int.1)

…I think what we are able to do is assess and measure against some relatively simplistic measures so whether that’s about evidence of undertaking a number of hours of CPD or cycles of CPD we would be able to do that. Whether an individual has attended a number of clinical training events…it would, so in that sort of approach we would absolutely be able to do that. If it’s, if it’s an assessment of an individual’s clinical knowledge outside of the areas I’ve, I’ve already mentioned in terms of service provision…where we would absolutely do that, outside of that I don’t think it, it would be very easy for us to be able to do that in an employment situation. (Employer 6b, int.2)

Some interviewees were unsure of what would be involved in the modification of the appraisal processes to accommodate revalidation. Nevertheless, there was an
appreciation that changes were necessary to evaluate an individual for revalidation, making comments such as:

"I'm not quite sure as to how that is gonna completely pan out with the, you know, with respect to revalidation. I think you know obviously there'll be an obligation to ensure that we support everybody as much as we can in that process but what that process will actually look like I'm not a hundred percent sure and I'm not completely sure either who, who will be leading that." (Employer 2, int.1)

From the perspective of the interviewees, it appears hard to address what standards were satisfactory in order to be able to practise pharmacy, and how exactly to measure fitness to practise, which is clear from some comments made:

"I think there's a clear, there's a clear line between kind of fitness to practise and kind of gross misconduct and performance, because actually again as pharmacists you know it's hard to measure yourself and it's hard, it's hard to get an understanding of how you're perceived by, by a patient, by customers you know and so it's, it's hard to, it's sometimes hard to measure your own performance in that way. And I think with, with revalidation that's probably gonna be a bit tricky of how do you, you know, how do you revalidate? 'Cos it's, it's not like a tape measure, you can't really measure people so you've gotta find a way of actually trying to assess, you know, what is performance and, you know, what would you or what would you like to see? I know the RPSGB have the documents around kind of core pharmacist responsibilities and what they should be achieving…and if you actually read that you'd probably go home depressed and I doubt there's a single person in the UK doing it…" (Employer 6a, int.1)

When an interviewee from Employer 2 was asked if there was anything in place within their organisation that could contribute to revalidation, such as professional and clinical issues in particular, they were unsure due to the ambiguity surrounding revalidation requirements:

"No 'cos I think it's a little bit about the fact that you know what can you say…what, what you know what are you validating to?" (Employer 2, int.2)

They also expressed that difficulties may arise in the revalidation of different pharmacists:

"…this is where you need something specific and this is what…and you need something relevant you know if there's an attempt under the quality agenda to make you know every individual Community Pharmacist, the Consultant Pharmacist or a Consultant Pharmacist in hospital then we are definitely barking up the wrong tree but if its relevant to their practice then that's appropriate." (Employer 2, int.2)
2.5.2 Independent Pharmacies

2.5.2.1 Pharmacy technicians

A formal appraisal system was in place within four of the nine independent pharmacies that were interviewed. Within the independent pharmacies that did appraise pharmacy technicians (Independent 1, 3, 8 and 9) there were some comments about how the appraisal might contribute towards a process of revalidation, for example:

> I think probably once revalidation comes in this appraisal is probably not fit for purpose [for] that… it’s, it’s… I think it could be, it, it could be amended to become, become fit for purpose but […] it would have to be a lot more detailed and structured in, in the sense of what they were expected to […] achieve within their own revalidation needs. (Independent 9)

Those interviewees that did comment on the potential contribution of their organisation’s appraisal system for revalidation purposes agreed that the appraisal itself would not currently fulfil the perceived requirements for revalidation.

2.5.2.2 Pharmacists

As there were no formal appraisal systems in place for pharmacists within the independent pharmacies, interviewees were asked instead to provide general comments about appraisal methods and revalidation concerning pharmacists. Some of these comments included:

> […] I think if we go down the revalidation route it’ll have to be by peer review… I don’t think we can cope with that as well. Well I think we’d have to, we’d have to get somebody external to, to help us out with that sort of stuff. (Independent 8)

> I would kind of hope that fitness to practice would be dealt with as and when necessary. It’s not something you could wait for, for that… for that performance review because that would be a really scary thing you know if you really felt you employed or were employing somebody that wasn’t fit to practice I would hope you would do something long before you would wait for their next performance review. I think performance review to me is more about the icing on the cake, you know, the, the basics I would expect […] And if I had a pharmacist that wasn’t even at the given stage I would be doing a lot more about that than leaving it… for a performance management issue, I think. To me performance management is the crème de la crème you know like getting staff from being okay to being fab… and again I don’t
A caveat with regards to the introduction of revalidation in community pharmacy in the future was pointed out by one interviewee:

*I mean the big, the big problem we’re gonna have in community, in a rural area like this is when revalidation comes I guess we will probably lose two of our pharmacists who are at the end of their career or right at the end of their career. I mean I’m 53 I’ve got pharmacists who are 63 and 64, I guess they’ll not want to go through revalidation they’ll just say, ‘Right I’m, I’m quitting’ so I, I guess when revalidation comes we’ll lose some of the older pharmacists who just can’t be bothered with it.* (Independent 8)

### 2.6 Who is responsible for the fitness to practise of pharmacists and pharmacy technicians

This section considers the views held about who is responsible for the fitness to practise of pharmacists and pharmacy technicians within the community pharmacies interviewed. As most interviewees were superintendent pharmacists from chain pharmacies or pharmacy owners from independent pharmacies they were asked directly if they felt responsible for the fitness to practise of their pharmacy staff. The support role of the superintendent in monitoring staff performance was also discussed in some interviews. This demonstrated the responsibilities these individuals hold pertaining to their staff’s performance and practice on an ongoing basis

#### 2.6.1 Chain Pharmacies

Employer 3 commented about the process of dealing with poorly performing pharmacists led by supporting pharmacists with the help of the personnel department. They, as superintendent, would monitor the progress of those that were not meeting quality targets or were making dispensing errors:

*…ultimately I would, as Superintendent, have an overall view of that I would expect them [support pharmacists] to, to keep me informed at the beginning of any process like that, during any process like that, and, you know, at the end the reassurance that*
things were now moving forward, or not, as the case may be of course. (Employer 3, int.1)

A similar process was in place within Employer 1 whereby the superintendent liaises with staff throughout a problematic incident:

In terms of dispensing errors it, it would…we have obviously SOPs for how to handle dispensing errors and it’s, it’s zero tolerance I’m afraid you have to…once a pharmacist is aware of a dispensing error he must report that to his line manager and store manager immediately and then they give him forty eight hours to investigate the error and that then has to be reported to me using a form on the intranet and that can just go into my email. I respond to every single error myself and usually there’s a question, I have a standard and they’ll be kind of, “Have we done this, have we done that?” “What…how was the customer?” “What else do we need to do to make sure the customer’s okay?” “What have we learnt from it?” “What actions are we gonna be putting in place?” they’re kind of standard responses. (Employer 1a, int.1)

The superintendent within Employer 6b takes responsibility for performance concerns such as dispensing errors made by pharmacists (generally locums) that are coming into a branch within the organisation:

…if there is an experience that perhaps another community pharmacy operator has had about a particular individual. I suppose that might be mostly applicable to locums…but if they have some concern about performance and they felt that there was a patient safety issue and they were aware that, that they were also employed by or engaged by [name removed] then I would expect that we’d get some contact and normally that would be between the Superintendents. (Employer 6b, int.1)

The superintendent and associated team of staff within Employer 7 make themselves available for any concerns occurring in the pharmacies within their organisation:

…we have a pharmacist feedback mechanism whereby branch teams can put the information on from key things that we want to know about, our employee pharmacists and indeed our locum pharmacists. So…if they’ve got a concern they can feed that through the pharmacist feedback system or they can email into the superintendent team any, any concerns that they’ve got or just to ring, ring us up. (Employer 7a)

Some interviews did point out that the superintendent was not solely responsible for the fitness to practise of their pharmacy staff, and that some responsibility did indeed rest with the practising individual:
I feel responsible for providing them with the opportunities and encouragement to keep up to date and to be as ready to practice as is possible within the environment in which they work. I don’t feel individually responsible, I mean obviously, I feel also responsible that we are able to spot anyone who wasn’t fit to practice and that we would have our own means of dealing with them. (Employer 3, int. 2)

I mean ultimately I’ve, I’ve obviously got the accountability for the quality of the service that, that is provided and in my role it’s, it’s both for Superintendent and the Professional Standards Director…so in terms of re competence of our people to be able to provide a service professionally…then I think we absolutely have some responsibility around that. I think there’s a shared responsibility with the individual practitioner because we obviously employ pharmacists to be competent in the role that they undertake and clearly Code of Ethics obligations means that they should not be practising in an area that they do not feel that they’re competent. Equally, as a Superintendent, I wouldn’t want and would not allow our business to put a pharmacist into a position where they are not able to practise competently. So, so I think it’s a shared accountability to that extent…but, yes, we [superintendents] absolutely have accountability around it. (Employer 6b, int.2)

2.6.2 Independent Pharmacies

Not all interviewees from the independent pharmacies provided information about who is responsible for the fitness to practise of pharmacists and pharmacy technicians. In the interviews conducted for the revalidation project, two independent pharmacies (Independent 8 and 9) were asked to share their views on this matter.

The interviewee from Independent 8 stated that they – as pharmacy owner – did feel responsible for the fitness to practise of their staff whereas the response from the interviewee representing Independent 9 was slightly more complex. When asked if they felt responsible for the fitness to practise of their pharmacy technicians and pharmacists they replied:

…well I suppose you know…the ultimate, the ultimate sort of responsibility for their fitness to practise lies, lies with them and [General Pharmaceutical Council], right…but, but as a, as a fellow colleague and things like that sort of…you know it would…it’s also if you like of interest and importance to me that you know the local pharmacists are, are fit for practise, yeah. So […] I don’t think it’s a full on responsibility if you see what I mean but…but there’s a responsibility as a professional to ensure that you know the people we employ […] are effectively doing you know okay, in doing what they’re supposed to do really. (Independent 9)
2.7 Difficulties in assessing another pharmacist’s skills / abilities

In conducting the second round of interviews with chain and independent pharmacies, the issues of whether there may be difficulties for a pharmacist to assess another pharmacist's skills / abilities, e.g. for an appraisal / revalidation assessment was explored. This section is pertinent to pharmacists only.

2.7.1 Chain Pharmacies

A number of interviewees from the chain pharmacies gave their opinion on whether there may be difficulties for a pharmacist to assess another pharmacist’s skills / abilities. Responses to this question included:

*I think peer evaluation can be quite good as long as the appraiser is you know has the right skills to do it.* (Employer 2, int.2)

When this interviewee from Employer 2 was asked if this may be difficult due to the fact that both individuals involved would be pharmacists, they replied:

*No, given that there’s, there’s always an…there’s also…there’s always going to be a flexibility with professional interpretation around most issues and you know that could be exercised to a lesser or greater extent…depending on how, how you know how, how the two get on I guess but you know fundamentally there are things there that you know that you can’t disagree about so you know you would, you know you would probably focus on that for simplicity.* (Employer 2, int.2, p.9)

Other interviewees shared their views on whether there may be difficulties for a pharmacist to assess another pharmacist’s skills/abilities as well:

*There ought not to be but it’s not something we’re used to […]. I think there’s an increasing move to it ‘cos I mean it’s difficult to divorce all clinical abilities with business, for instance, if, you know, I know that if our Area Support Pharmacists were appraising their Pharmacists and they failed to get accreditation to provide a local enhanced service…that I’m sure that will be raised in their appraisal. And equally, you know, the dreaded word MUR, you know, is a clinical service, whatever you say, it’s a type of clinical service shall we say, and professional service and, you know, clearly where Pharmacists aren’t contributing at all, there, you know, there is a…that would come into appraisal time, you know, it’s failing to achieve a business in terms of income, but, you know, we need to address why they don’t see it as also being clinically being part of their role.* (Employer 3, int.2)
No, I don’t…actually I think [...] because I’m not sure that actually that’s the purpose of an appraisal - to start challenging and so on and so forth. An appraisal is a discussion around about, you know, what’s happened and…and how you might develop in the future and so on and so forth…and I think personally I think of these…it is a good opportunity to share thoughts and views between two professionals working in the same environment. Now, clearly, if there is an issue, then we would get somebody else involved, including HR professionals or store management, or whatever…to understand what the issue is, but frankly, in terms of challenging performance, that would be done outside of the appraisal scheme I think. (Employer 5b)

There, there could be…I, I think the credibility of the person doing the assessment I think is important and something quite so significant as professional revalidation…I think would need to be done with, with a lot of care around that area. The credibility of the person who’s doing that review and ultimately you know rubber stamping to say, ‘Yes this person is fit to practise’, I think that’s quite a big responsibility…and I think, I think you would probably find that people wouldn’t take that responsibility on lightly and would need an awful lot of support in order to be able to do that, to feel that they were doing it justice. (Employer 6b, int.2)

I think if we had a robust enough test…that’s you know that’s very transparent, I don’t see why not you know, we have one Manager assessing another Manager’s skills and I don’t see why it would need to be any, any different from a Pharmacist assessing another Pharmacist’s skills as long as we have something that is very reasonable that we can validate, that we know…that we know is a good test and that we can, that we can rely on really. (Employer 7b)

2.7.2 Independent Pharmacies

A few interviewees provided information that related to the difficulties in assessing another pharmacist’s skills and abilities. One interviewee (a pharmacy owner) commented on this more implicitly from an earlier interview that did not specifically ask questions about this issue:

I’m employing a professional to do a professional job, you know, if they’re qualified and competent, you know, qualified then who am I to sort of question that. (Independent 3)

When the interviewee from Independent 9 was asked about this matter directly they said:

I think it depends on, on the individual concerned but you know some individuals are, are a lot more prickly about their, their you know abilities and things. And you know so…the thing on…they, they have got…on their hand have got to be prepared to accept you know like constructive criticism…and you’ve gotta, the persons…those people giving it have gotta be you know able to sort of deliver it in a way which
doesn’t, doesn’t...you know sort of maybe throw the baby out with the bath water. So, so I think, I think you know that’s again I think another sort of training need which is...which, which would need...which needs to be looked at...how can you cope with doing peer reviewing. (Independent 9)

2.8 Summary and discussion

Some of the key results from the qualitative analysis of the interviews in community pharmacy will be summarised and discussed while considering the implications the findings have on revalidation.

2.8.1 Chain Pharmacies

Those chain pharmacies that were interviewed did have systems of appraisal and performance monitoring in place and they were generally conducted by the pharmacy technician’s and pharmacist’s line manager, though in many instances the line manager was a non-pharmacist.

The appraisals focused mainly on business performance and objectives. The clinical performance of pharmacists appeared to be less of a concern. Pharmacy managers in more senior positions (who were non-pharmacists in many cases) aimed to drive the business objectives and targets. Those managers that may have been pharmacists were carrying out these tasks as well, and were not being appraised on their pharmacist (i.e. fitness to practise) skills. It is not clear whether those managers who were pharmacists brought elements of professional skills associated with being a pharmacist to their job roles. As many senior managers were not required to be pharmacists for their position as a manager, such skills may not be put to use as they do not play an essential part in the individual’s job role.

The superintendent pharmacist was generally appraised by a senior business executive, and they were not assessed on fitness to practise related issues, but more on managerial and business skills. Still, superintendents felt responsible for the fitness to practise of their pharmacy staff. There was the belief from interviewees (mostly superintendents) that superintendents were responsible, at least in part, for the fitness to practise of their pharmacy staff. There was also belief that some
responsibility rests with pharmacists who should be fully competent to conduct their job properly. Although there was this sense of responsibility amongst superintendents for the fitness to practise of their pharmacy staff, it is surprising that appraisal systems, for example, do not seem to cover a wider range of fitness to practise issues which could support the quality of practice provided by pharmacists within the organisation.

The consensus from chain pharmacies was that the appraisal systems currently in place were not suitable for revalidating pharmacy technicians or pharmacists. A minority suggested that their appraisal methods would cover only some aspects of assessing fitness to practise for revalidation but no system in place within the chain pharmacies interviewed seemed sufficient in assessing a pharmacist’s fitness to practise fully. Routine monitoring was in place within chain pharmacies in addition to the appraisals but this did not appear to be useful for revalidation purposes.

Most interviewees did not consider there to be any difficulties with the proposals of having a pharmacist assessing another pharmacist’s skills/abilities. However, some interviewees pointed out that certain things would have to be met for this to roll out for revalidation, for example, proper training provided to assessors and having a robust test in place.

2.8.2 Independent Pharmacies

Independent pharmacies did not have any formal appraisal processes for pharmacists and therefore major work would need to be carried out to allow a revalidation process to be developed and implemented in this sector. The appraisal of pharmacy technicians was carried out in some cases but it is not likely that these appraisal processes are capable of being a source of evidence for revalidation. Appraisals of the most senior staff (pharmacy owners) were not carried out in two of the nine independent pharmacies interviewed. It was not clear whether the pharmacy owners in the other seven independent pharmacies were appraised, though with a lack of appraisal systems for other pharmacists it may be likely that pharmacy owners were not appraised in these organisations either. It appears that these individuals are not strictly monitored much like the other employed/locum...
pharmacists within these organisations. Therefore, there may be the need for an external body to be involved in overseeing the revalidation process of pharmacists within independent pharmacies.

2.8.3 Locum Agencies
Locum Agencies do not currently play any role in appraisals. This is likely to be outside of their domain of expertise, partly because of the absence of a pharmacist with sufficient understanding of competence and fitness to practise among pharmacy professionals within the industry. Therefore, it does not seem that locum agencies are currently in a position, or see they have responsibility, to carry out such monitoring or contribute to the revalidation of pharmacists or pharmacy technicians.

2.8.4 Conclusions
Currently, there appears to be no system in place which has the capacity to be used for revalidation purposes within community pharmacy. There are measures in place (primarily within chain pharmacies) which examine different aspects of a pharmacist’s or pharmacy technician’s performance, however, they do not appear to cover most areas of one’s fitness to practise. For example, in many cases clinical performance was not something that was monitored at all. Indeed, in many community pharmacies the focus was more on business targets, which also appeared to be more clearly defined and thus much easier to measure and monitor.

A major issue concerning revalidation, based on the interviews conducted, is the fact that locum pharmacists and pharmacy owners seem to be unmonitored in their workplace(s). Locum pharmacists did not appear to be appraised in any context, be it within chain or independent pharmacies. This was mainly due to the fact that they are not considered employees. They could be flagged reactively by other members of staff or through customer complaints, but they did not undergo a formal appraisal as other employee pharmacists did, and thus no proactive appraisals were in place. Locum agencies who deal with these pharmacists on a regular basis were not suitable to appraise locum pharmacists either. There is not much governance over
these individuals within pharmacy and more would need to be done to ensure these individuals were fit to practise in their place of work.
3 Pharmaceutical industry stakeholder representatives’ views on appraisals and their relevance for revalidation

3.1 Introduction

Pharmaceutical companies range in size from relatively small companies to multinational organisations. Broadly speaking, the work of the industry involves developing, manufacturing, distributing and marketing medicines. Pharmaceutical companies are typically divided into different departments which focus on these areas of work, as well as other departments which may deal with general corporate functions, although the exact structure varies between organisations. Pharmacists can conceivably be employed in any area of a pharmaceutical company, although they are more likely to be found working in research and development, compliance/quality assurance, manufacturing or communications related roles. The most recent (2008) pharmacy workforce census showed that 4.1% of registered pharmacists in Great Britain worked within the pharmaceutical industry.²

Unlike the sectors of practice where the majority of pharmacists work – hospital and community pharmacy – where there are specific functions that can only be carried out by a pharmacist, within the pharmaceutical industry, there are no tasks or functions that are exclusive to pharmacists. The main difference between pharmacists working in the pharmaceutical industry and those employed within the hospital and community sectors is that the focus of their work is not directly patient-facing. The main similarity between the community pharmacy sector and the pharmaceutical industry is that employees are working for private sector organisations, as opposed to the NHS. The work of the pharmaceutical industry focuses on material ‘products,’ that is medicines, whereas the other sectors of pharmacy practice are within ‘service industries’ – mainly health and education. Pharmaceutical companies operate within a highly regulated industry; a considerable amount of guidance and legislation related to the manufacture of medicines is in place, much of which is produced and monitored, mostly carried out by the national
regulator for the production of medicines, the Medicines and Healthcare Products Regulatory Agency (MHRA).

### 3.2 Aim and method

The aim of this study was to ascertain the current structure and content of existing pharmaceutical industry appraisal systems and to explore whether these systems could inform, or be developed to inform, revalidation processes for pharmacy professionals. To address this aim, semi-structured qualitative interviews were conducted with pharmacists working in pharmaceutical companies. The sampling strategy was purposive and we included pharmacy professionals employed in a range of different organisations, based in different areas of England and Scotland (there is no pharmaceutical industry in Wales) and undertaking different roles. In total, nine interviews were conducted with seven pharmacists and two pharmacy technicians employed in seven different pharmaceutical companies in England and Scotland. All participating pharmacists were on the ‘practising’ pharmacists’ register.

Table 7 summarises the areas of work in which the participants in this study were employed. The interviews were conducted by telephone between April and May, 2010, were recorded and transcribed verbatim. The transcripts were analysed using a thematic approach. Initially, analysis was guided by the semi-structured interview schedules (see Appendix 2), then also by the data themselves.

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Area of work</th>
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<tbody>
<tr>
<td>Pharmacist 01</td>
<td>Compliance (is also a nominated signatory)</td>
</tr>
<tr>
<td>Pharmacist 02</td>
<td>Research and development</td>
</tr>
<tr>
<td>Pharmacist 03</td>
<td>Research and development</td>
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<td>Pharmacist 04</td>
<td>Regulatory affairs</td>
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<td>Pharmacist 05</td>
<td>Drug development</td>
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<td>Pharmacist 06</td>
<td>Medical information</td>
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<tr>
<td>Pharmacist 07</td>
<td>Quality assurance (is a QP)</td>
</tr>
<tr>
<td>Pharmacy technician 01</td>
<td>Communications</td>
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<tr>
<td>Pharmacy technician 02</td>
<td>Parallel imports</td>
</tr>
</tbody>
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Table 7: Pharmaceutical industry interviewees’ areas of work
3.3 Findings

3.3.1 Coverage of appraisal systems within organisations

All of the participants in this study were employed in organisations which had company-wide performance management processes. These processes all included systems for monitoring and recording individual employees’ performance and development. In all of the organisations included in this study, all permanent members of staff were covered under the performance management system, which includes appraisals. All of the participants in this study were permanent employees of their organisations, and reported that there are very few non-permanent (e.g. contract or other temporary staff) working within the industry, however, where these staff are appointed, they are not included in the performance management process.

3.3.2 Who is involved in conducting appraisals

Data from this study show that pharmacists and pharmacy technicians in the pharmaceutical industry are sometimes appraised by pharmacy professionals, but not necessarily, as described by the pharmacist in the following quote:

...as a pharmacist I have [conducted appraisals] with other pharmacists but...we tend not to wear labels that say, “I’m a pharmacist, I’m a chemist” or whatever and so yeah I will have had a range of staff with different scientific disciplines and backgrounds that I’ve done that for. And similarly for me I’ve had line managers who’ve been pharmacists and line managers who haven’t…who’ve conducted that process with me. (PI pharmacist 02)

In all companies, appraisals were carried out in a one-to-one meeting between an employee and their line manager. Typically the appraisee would complete the relevant paperwork and send it to their line manager a week before the appraisal. This ‘employee driven’ approach was generally thought to be a good one:

...very much person-driven as opposed to the manager filling everything in. The person is expected to complete most of it ahead of what they do, ahead of the meeting and then they hand it to the manager four or five days before the meeting, so the manager then has time to read it and digest it and come up with any other bits and pieces that they want to bring up...But there are other previous systems which were very much manager driven, where the manager would do all the filling in of the form before the person arrives and we found that wasn’t quite so good. (PI pharmacist 03)
Sometimes the line manager will seek feedback on performance from people the individual has worked with and that will inform the one-to-one discussion:

*I do not have line management responsibility for the people in the project teams that I lead. I do take part in the review processes for the individuals in my project teams because...if you like I'm a key customer for everything that they do so I am required to provide feedback on their performance and quite often I'm asked to provide feedback in terms of the behaviours that they've exhibited and whether...how they fit with leadership capabilities and that sort of thing.* (PI Pharmacist 02)

*I do not have line management responsibility for the people in the project teams that I lead. I do take part in the review processes for the individuals in my project teams because...if you like I’m a key customer for everything that they do so I am required to provide feedback on their performance and quite often I’m asked to provide feedback in terms of the behaviours that they’ve exhibited and whether...how they fit with leadership capabilities and that sort of thing.* (PI Pharmacist 02)

*...our process does involve feedback. The way it’s done at the moment, and this is really because it’s relatively new to the organisation, is that the manager seeks feedback about each employee, and that’s generally done through agreeing with the employee who you’re going to talk to...*(PI pharmacist 06)

Objectives are usually set annually, typically at the start of each calendar year and the appraisal is focussed on reviewing achievement against these targets. Commonly, company objectives cascade down into departmental, then group and then personal objectives. For managers, this means that each year they will look at the company objectives and see what each individual needs to do in order for the organisation to meet those objectives, make sure they are trained to carry out their tasks, and then be checking to see how the individual implements their training and performs against their objectives:

*...having looked at the objectives of what the company has we will then look at what each individual needs in order for an organisation sort of to fill those objectives. So for an example if I’m talking about manufacturing...by design, you know, is the big thing in manufacturing, I then have to make sure that my...people are you know are well versed in quality by design techniques and design of experiments and if they haven’t had design of experiment training they should get design of experiment training...which may well involve somebody coming in from externally and we might run a course in-house for six or seven people, I then want to see so as an individual you know are you now implementing the design of experiments training that we did.* (PI pharmacist 03)

There was also evidence that performance objectives may be linked to monetary incentives:

*In reality the focus is very much on the front end, the performance objectives and behavioural, sort of, objectives, because those directly link to the bonus that people are paid.* (PI pharmacist 07)
3.3.3 Appraisal documentation

Copies of appraisal documentation were provided to the research team from six of the seven companies included in this study. One of the pharmacists interviewed was unable to provide us with a copy of the forms used within their organisation.

All of the appraisal systems shared an overall aim of reviewing achievements since the last appraisal, identifying areas for improvement and making plans for future work. The most ‘basic’ appraisal paperwork contained open ended questions asking the employee to describe their achievements; their areas for development; training needs and goals for the coming 12 months; to discuss these with their manager and specify some ‘action points’. The other five appraisal systems were more structured, with tables set out for employees to complete. All five focussed on objective setting, with tables for the employee to define their individual objectives, and then break each one down into more specific ‘standards’ or ‘measures.’ Two organisations used ‘weighting’ systems, where the employee would prioritise their objectives by assigning a percentage weighting to each.

Three companies made a distinction between ‘performance’ (outcomes or results), and ‘behaviours’ within the appraisal paperwork. One of these had a table for ‘results’ and a table for ‘core company behaviours’, where these were assessed in terms of ‘not met,’ ‘fully performing,’ or ‘exceeding.’ In another organisation’s appraisal document there was a table for recording assessment of the employee’s objectives in terms of their accomplishment of the measures for each objective, and a table where the employee selected up to three ‘high performance behaviours’ from a list of 12, and again assessed their own accomplishments of the ‘expectations’ that had been set for these. The third company used a ‘key performance factors’ table, where employees rated themselves on a scale for each factor.

3.3.4 Other guidelines – working within a highly regulated industry

Participants in this study believed that they worked within a highly regulated and monitored industry, and when asked about revalidation, several spontaneously mentioned other regulations, standards or guidelines which they had to comply with, or monitoring activities, such as audits, that were routinely carried out. The MHRA is
the national regulator which covers the pharmaceutical industry. ‘Good manufacturing practice’ (GMP) is that part of quality assurance which ensures that medicinal products are consistently produced and controlled to the quality standards appropriate to their intended use and as required by the marketing authorisation (MA) or product specification. The GMP guide, commonly referred to as ‘the orange guide’ or ‘the orange book’ was mentioned by several interviewees as a key reference source:

…the QA unit here, which has responsibilities for… the documentation reviews for manufacturing and packaging and… ultimately the QP release of the materials and…the quality system as a whole and we do validation activities which maintain the facility and the equipment and the computerised systems to the appropriate GMP standards. (PI pharmacist 07)

…the Orange Guide’s our bible here really. (PI technician 01)

In the following two quotes, both interviewees explain that standard operating procedures (SOPs) are very widely used within their workplaces, and they are therefore familiar with having written procedures in place that specify in detail how virtually every task must be undertaken:

I have to work through so many SOPs to do my job… my training is really my file so when the MHRA come in they say, “How do we know she’s competent to do that if she signs this document?”… day to day stuff. If I’m completing a task I’ll have to have undergone training… even if I’m opening the back door… you have to unaided and aided assessment on it. Everything I do I have to, …my training record has to be completely up to date. (PI technician 01)

There seemed to be a perception among interviewees that the pharmaceutical industry was particularly highly regulated, and more so than other sectors where pharmacy professionals are employed. One pharmacist reported a similar way of working to the pharmacy technician quoted above, and also compared her sector of work with community pharmacy, where she thought that the use of SOPs was less well established, and people were less familiar with them:

… not so much hospitals, but certainly in community you’re, ‘Oh, gosh we have to write a standard operating procedure’:… we have a standard operating procedure for calculators for god sakes… you are only supposed to use a company verified calculator… (PI pharmacist 05)
The practice of auditing was seen in a similar way. A pharmacist and a pharmacy technician (working in different companies) both raised the issue that auditing is a regular activity within the pharmaceutical industry. Again this quote from the pharmacist suggests that this has been the case within industry perhaps to a greater extent than it has for other sectors of the profession:

...a few years ago when the pharmacy profession got itself all wound up about audit and self audit and it’s like, ‘goodness me, it’s the industry’, you know, we get audited all the time. And there was all this big hoo-ha about auditing, come on...[here] like every month nearly, somebody is auditing you for something. (PI pharmacist 05)

3.3.5 Potential relevance of existing systems for revalidation of industrial pharmacy professionals

Participants were asked which parts of the existing tools used for appraisal within their organisations were useful for assessing the fitness to practise of pharmacy professionals, and therefore whether they might be relevant or useful for revalidation. Although participants did not report any ‘problems’ with the systems in place for assessing their performance against objectives related to their roles within their company, they did not perceive them to link directly to the assessment of their work ‘as pharmacy professionals.’ No participants saw the appraisal system used within their company as an assessment of anything specifically related to working as a pharmacist or pharmacy technician. One interviewee explained how he thought that he was being appraised within his professional role, but he did not see anything within the process that appraised him as a pharmacist:

Interviewer:...in terms of your...in terms of your fitness to practice as a pharmacist, do you think there’s...do you think there is there anything that specifically assesses that at the moment?

Interviewee: No. I don’t think there is. It’s down to me as a professional, and... I’ve not operated as a pharmacist outside industry for the last twenty years. I’m fully happy that I...am competent as a quality assurance professional who happens to be a pharmacist. (PI pharmacist 07)

Another interviewee held similar views:

In my review with my manager...he’s not in any way judging whether I’m complying with my professional standards of pharmacy. (PI pharmacist 01)
When asked whether they intend to stay registered as a practising pharmacist in the future (after the ‘non-practising’ register ceases to exist), all pharmacist interviewees stated that they would wish to remain registered.

A pharmacist with considerable experience (and now working at a senior level of ‘medicines information’ work within the pharmaceutical industry), emphasised the diversity of roles for pharmacists within the industry. She drew parallels between pharmacists working within her ‘niche’ and their counterparts in the NHS. In contrast to the quotes above which suggest that in industry, often, being a pharmacist has low importance, she felt that this was an area of work where pharmacists did tend to be ‘enthusiastic’ about their role ‘as pharmacists’:

... there’s a broad variety of roles, the role that we have in the Medical Information environment is very, very different from pharmacists who work in formulation, for example, are very, very different from the people who work in production...[in Medicines information]we can draw on some of the parallels with the medicines information pharmacists in the NHS...that’s the closest comparison to the role we have. We have a lot of similarities to their role. Obviously, there are differences, but there are some commonalities there. Those in Medical Information are very enthusiastic and tend to see themselves as pharmacists... There are a couple of other pharmacists who work in more, sort of, sales and marketing environments who were not particularly interested, and you know, I don’t know whether they would stay on the practising register or not...(PI pharmacist 06)

3.3.6 Who should be responsible for the revalidation of industrial pharmacists and pharmacy technicians?

Questions about who should oversee and carry out revalidation for pharmacists (and pharmacy technicians) elicited mixed responses from interviewees in this study. This pharmacist reflected on the diversity of roles that pharmacists undertake within the industrial sector, and seemed to suggest that there are certain elements of some roles which can be considered to be ‘pharmacy practice,’ but that pharmacists are also undertaking jobs which involve elements that are outside ‘pharmacy practice’ and that this complex situation makes it difficult to judge who should assess pharmacists’ fitness to practice.

... I think that that’s very difficult to give a single answer to because you have pharmacists who are doing roles which are nothing to do with pharmacy...and you have people who are qualified persons in, in manufacturing... and then you have
people who… are acting as signatories and reviewers for ensuring ethical and compliant promotion. You have pharmacists who are acting as medical information officers… you know, pharmacists who are acting as clinical trials monitors… so within that then there are elements of that which you might say are related to pharmacy practice but in other pharmacist’s jobs there aren’t. (PI pharmacist 01)

Some industrial pharmacists felt that revalidation was a role for their professional regulator:

Oh the General Pharmaceutical Society, definitely... Yeah I’d be very upset if it’s not going to be... I think that CPD is probably what the General Pharmaceutical Council should be doing because they’re looking at a set of minimum standards aren’t they? Whereas the appraisal system within companies is looking at who the high flyers are and looking at what training needs are, are required……and whether people are...competent but the mix I think that the company systems…don’t directly relate to what the General Pharmaceutical Council should be doing.(PI pharmacist 04)

However, the pharmacist quoted below felt that managers who were actually in contact with pharmacists in their workplace were better placed to carry out revalidation, because they observed pharmacists in practice.

I think the people better placed should be the line managers, frankly. I think if I, sort of, look at the staff in my group, then people who are better placed to assess them, whether they are competent as industrial pharmacists and qualified persons, are their line managers. And I think no matter what you might create as a documented portfolio as it were, and one externally, it’s never going to be as well positioned to assess your competence as the person you interact with on a daily basis. (PI pharmacist 07)

One pharmacist suggested that perhaps a joint approach between the professional regulatory body and the organisations where pharmacists are employed would be best:

I don’t know you either, either have a system where…the [company] system is accredited or something in some way is providing appropriate reassurance…for validation and you have...somebody in, in a company who’s a pharmacist to, to do some kind of check or provide the reassurance to the GPhC, that might work. Or maybe some local arrangement for reviewing those sorts of things might work. I think …the question then is, ‘Who is, who is most qualified to make that judgement’?… It’s a difficult one I think. (PI pharmacist 02)

Another pharmacist felt that it was important that pharmacists who understand the industrial environment are involved in the revalidation process, but raised the practical issue that smaller companies might lack sufficient resources to do this:
...there definitely needs to be an input from other industrial pharmacists who understand the environment... so quite how you achieve that it’s... it is difficult to work out... I there’s a bit we can do internally, but we’re quite small numbers... you know, in larger pharmaceutical companies it would probably be relatively easy to work a way of doing in internally, although whether arguably you should have some mechanism that brings in somebody from outside your organisation, it think ... (PI pharmacist 06)

The perceived variation and diversity of roles undertaken by pharmacists within the pharmaceutical industry was again raised by this pharmacist. He also referred to the highly regulated nature of the industry and explained that because there is a lot of detailed involved, the situation can be quite complex, he was concerned about whether decision-makers in the professional body would have sufficient knowledge and experience of these to be able to revalidate pharmacists working in these areas ‘effectively’.

...I was very disappointed that the GPhC has no industrial leadership on the committee.....and I think that’s a woeful issue...because they’re not representative of the whole sector of pharmacy...right now I’m not confident of the mixture of individuals in GPhC...to do that properly... if it gets too technical...you know I shall be concerned if they, if they start to revalidate technical competence cos I can tell you that’s quite difficult to do...first of all there are various sectors... for example are we gonna start revalidating whether they can make tablets or not?... you’ve gotta bear in mind we operate within very strict SOP’s and training guides... so all that training is done as part of our own internal processes... [each company develops what they need] but they always conform bearing in mind to regulatory needs so for example this site... has been developed by the food and drug administration... you need the regulation... its [company]’s own internal policies which allow us to conform to the various regulatory agencies around the world, okay?... So I’ve got to be trained... up to date... I’ve gotta be fit to practice, I’ve gotta be able to show [that]... all that’s gotta be collated in a document.  (PI pharmacist 05)

3.3.7 Issues relating to particular roles or ‘subgroups’ within the pharmaceutical industry

Two roles undertaken by pharmacists in industry in particular were raised by interviewees as of particular note concerning revalidation: qualified persons and nominated signatories.
3.3.7.1 Qualified person

A ‘qualified person’ (QP) is the quality assurance professional for medicines. It is a regulatory requirement (within the European Union) that every holder of an Authorisation to manufacture products for use in a clinical trial or products subject to Marketing Authorisations, must name a person or persons who are eligible to act in the capacity of QP. The primary legal responsibility of the QP is to certify batches of medicinal products prior to use in a clinical trial (human medicines products only) or prior to release for sale and placing on the market (human and veterinary medicinal products). The role of QP can only be undertaken by a pharmacist, a chemist or a biologist. The requirements for registering as a QP includes an assessment by an interview panel, which usually comprises one assessor from each professional body and is chaired by an assessor from the candidate’s own professional body.

In terms of ongoing ‘professional requirements’ for QPs after the initial qualifying assessment, no revalidation requirements were identified, although the ‘Code of Practice’ for QPs states that they have ‘a personal and professional duty to keep their knowledge and experience up to date (EU Guide to GMP, Volume 4 of the “The Rules Governing Medicinal Products in the European Union”). It is expected that this would cover the current state of pharmaceutical quality management, regulatory aspects and GMP guideline standards, product manufacturing and control technology, and general work practices. The code also refers any QPs who are registered pharmacists, to the ‘key responsibilities of a pharmacist’ set out in the Code of Ethics for pharmacists.

QPs were mentioned by four of the pharmacists interviewed in relation to revalidation. There seemed to be a general perception among these pharmacists that there were ‘special’ requirements for QPs in terms of ‘keeping up to date.’

[QPs are] critical to industry but I think somewhat neglected by the pharmaceutical society in the UK... you have chemistry QP’s and you have biology QP’s and the chemistry and biology people you know they sort of really respect the QP title and say you know someone that’s a QP is quite a special person. I don’t think the pharmacy group think the QP’s are special and they are quite special. I don’t think that’s well recognised... I don’t know what they need to look at, I don’t think it is a problem for them, I think it is something that is important that you know you have to keep the qualification up to being a QP, that has to be kept up-to-date... The QP side of it has to be kept up to date and I think it would be somewhat of blow if
somebody was keeping up-to-date as a QP and they were told, ‘well actually you’re not keeping up-to-date as being pharmacists… I’m sure that is also good to fit with the revalidation requirements. (PI pharmacist 03)

However, this pharmacist, who is also a QP, seemed to associate revalidation with CPD, and mentioned that the guidance for QPs emphasises the importance of maintaining CPD, but does not identify any specific requirements other than CPD that are related to revalidation.

Interviewer;…in terms of revalidation…what does that term mean to you? 
Interviewee: It’s a very good question. I’m not sure to be honest. I mean, for me I guess, sort of, we’ve got, particularly as a QP, there’s a requirement to undertake continual professional development, and sort of, the QP study guide that helps guide the areas that you should maintain a knowledge in. (PI pharmacist 07)

3.3.7.2 Nominated signatory

The role of ‘nominated signatory’ usually covers a set of responsibilities for final approval of specified materials and activities linked to promotion, interactions with healthcare professionals and organisations, and other related areas such as non-promotional health education materials. This means that they are responsible for signing off the certificate of approval for sales and marketing activities and related activities such as patient information activities. Usually, nominated signatories should have a degree in medicine, pharmacy, pharmacology or other relevant life sciences.

This interviewee outlined the role of the nominated signatory. Like the QP, it tends to be one ‘function’ undertaken as part of an individual’s overall ‘role’ or job.

…the nominated signatory say who is a doctor is probably the medical director…or the medical advisor, they have several roles one of which is nominated signatories……you know they also probably oversee clinical trials and they may do some medical information or you know they do other medical…look after pharmacovigilance and so…you know proving marketing output is just one of those roles…so nominated signatory is generally a role rather than a job. (PI pharmacist 01)

In one company included in this study, a group had been set up to oversee nominated signatories which had produced some guidelines on their training and accreditation, which the interviewee suggested could be relevant to the revalidation
of this ‘subgroup’ of industrial pharmacists. The guidelines cover the qualifications, knowledge and capabilities for nominated signatories (although the capabilities mentioned are the company ‘leadership capabilities’ defined by the organisation in question) and state that ‘a training programme should be devised and documented for each candidate nominated signatory, and this should be integral to their performance management and personal development plan. A continuing education plan should also be agreed and documented … as part of performance management.’ The document also suggests basic training on the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) code in order to understand the international context of national rules.

The interviewee in this study who works as a nominated signatory pointed to the existence of the professional body for doctors employed in the pharmaceutical industry – The Faculty of Pharmaceutical Medicine. They offer a two-year course and registration as a pharmaceutical physician and the Faculty are considering offering admission to non-medics, therefore, in the absence of a suitable scheme for UK industrial pharmacists this might be a viable alternative for a pharmacist working in a medical/ clinical/ regulatory role in industry.

In the medical profession, as part of the development of revalidation, all colleges and faculties were asked to draft specialty specific standards for revalidation. Each specialty’s standards are very closely linked to a GMC framework that adapts Good Medical Practice to four domains. The standards for pharmaceutical medicine and the suggested supporting information have been developed to assist doctors to prepare for revalidation. They will be applicable to all doctors with a GMC licence to practise who practise pharmaceutical medicine, whether on the specialist register or not. The draft document specifies standards and the types of supporting evidence that can be used to show that each standard has been met (e.g. practice audit, portfolio evidence, peer feedback).
3.4 Discussion

All organisations included in this study had performance management processes which included the use of appraisals consisting of a conversation between the employee and their line manager focussed on judging what has been achieved during the year and setting out what the expectations are for performance over the following 12 months, and documenting this. It is usual for performance expectations to be expressed as a set of ‘objectives’ or ‘targets,’ and for the meeting to also cover development needs and review training undertaken or make plans for future training.

Performance management in the pharmaceutical industry can be considered to focus on three areas:

1. Company objectives
2. Compliance with industry regulations – quality assurance, GMP
3. Personal career goals and development for the individual.

For pharmacists working in industry, there seem to be requirements on their jobs which may not fit easily into a revalidation model implemented by the professional body. On the one hand there are generic, company-wide objectives, which form much of the appraisal process, many of which may be commercially driven and relate to employee bonuses or promotions within the company. On the other hand there are very specific requirements which relate to the manufacturing side of the job, for example pharmacist 05’s concerns about how the professional body could revalidate pharmacists’ skills related to tablet processing.

It is interesting that although some of the pharmacists quoted in section 3.3.7 seemed to feel that in terms of their industry roles, their status as qualified pharmacists is, to an extent, incidental. However, they had no intention of relinquishing their status as ‘registered professionals.’ It may therefore be both interesting and important to explore further what is pharmacy specific to these individuals’ roles in the pharmaceutical industry, as this will also help inform revalidation in this sector.
Pharmacists in industry agree that they undertake a diverse range of roles, in a highly regulated industry, where they have to comply with a multitude of regulations and procedural guidelines, which makes for a complex situation. It is not easy to say who is best placed to revalidate the people in these roles, and the lack of consensus on this matter among pharmacists in this study is probably reflective of the complexity of the situation. However, it may be useful to look to the way the GMC plans to handle the revalidation of specialist practice, and specifically how this relates to those working in the pharmaceutical industry.\textsuperscript{8,10}
4 Schools of pharmacy stakeholder representatives’ views on appraisals and their relevance for revalidation

4.1 Introduction and method

There are 26 schools of pharmacy in the UK (25 in Britain) that offer undergraduate and postgraduate qualifications in pharmacy. Five schools of pharmacy were targeted for this research project in order to explore the appraisal systems they have in place and how they may contribute to a process of revalidation in the future. Five interviewees were selected from Russell group, ex-polytechnic, and new schools of pharmacy from a range of geographical areas of Britain. These individuals were recruited because they held a senior position within their institution and were involved in conducting and managing appraisals so were capable of responding to questions relating to appraisals within their workplace. They were all pharmacists and were either heads of school or pharmacy practice. The five interviews were conducted between November 2009 and May 2010 by telephone and were digitally recorded and transcribed verbatim. Each interview followed a semi-structured format (see Appendix 3 for topic guide). A qualitative analysis of the interview transcripts was carried out using the ‘Framework’ qualitative technique to identify and collate emerging themes relating to the research questions. The subsequent sections in this report provide the findings from the analysis.

4.1.1 Who conducts appraisals

The interviewees representing the schools of pharmacy were asked who would be responsible for conducting the appraisals of academic staff (including pharmacists) within their school. Every school of pharmacy had an appraisal system in place and it was generally conducted by an employee’s line manager who would not necessarily be a pharmacist. For example within one school of pharmacy (Academic 1), the head of pharmacy practice (a pharmacist) would appraise the members of staff within that group. The head of pharmacy practice would in turn be appraised by
the head of department (a non-pharmacist). The interviewee noted that this was not considered to be a problem:

*I am a registered pharmacist, I don’t really […] have a patient-facing role. I have a managerial role and a research role, and so being a pharmacist or not I… I’m not sure it’s that critical to evaluate what I do.* (Academic 1)

Within one of the schools of pharmacy, academics that underwent an appraisal had the opportunity to select a member of staff other than their line manager to conduct their appraisal. The appraiser could thus be a pharmacist or a non-pharmacist:

*So I’m… I’m [appraised] by my… my line manager and then I [appraise] the, sort of, ten staff that I’m responsible for, but anyone can choose to be [appraised] by whoever they want, they don’t have to be [appraised] by… by me or their line manager.* (Academic 2)

Within another school of pharmacy, the interviewee reported that they, as pharmacy practice manager, conduct between eight and ten appraisals each year for staff within the school of pharmacy. However, they would receive an appraisal from a senior chemist who was not considered an appropriate appraiser for them as a pharmacist:

*There is somebody within the school who appraises me every so often, I have to say that’s a very useless process. […] they always used to give me one of those senior chemists to appraise me and they had no understanding of my job, no understanding of my role, no understanding of my research area, so appraisals with them were a bit of a waste of time, it was just a tick box exercise.* (Academic 3)

Some interviewees explained the role of their institution in managing and appraising teaching practitioners. Interviewees reported that these members of staff went unappraised by the school of pharmacy, generally because they were not a full time member of staff and/or had another employer that would carry out the appraisal:

*They’re [teacher practitioners] appraised by their employers because we don’t pay them, we have service level agreements so in terms of formal characteristics that’s done by the employer.* (Academic 4)

*Now, I think whether they fit into our appraisal system, and I’d have to check this, depends really on the level of commitment… because obviously, if they’re… if, say, they’re here for just one day a week, which is quite often what we have… then they wouldn’t necessarily be appraised here. They would still be responsible, obviously,*
to the line manager for what they're doing, but I'm presuming that they would be in the system in their hospital or whatever. There is a guideline that I've seen...the university produce on, you know [...] if you're doing less than so many hours a year, or whatever, then you don't have to. (Academic 5)

4.2 How often appraisals are conducted

Four interviewees reported that appraisals were conducted annually. One of these interviewees said that there would also be an interim meeting that took place in addition to the annual appraisal (Academic 5). Another interviewee noted that their institution had variable time frames in which appraisals would be conducted (i.e. not always annually), dependent on the amount of time the member of staff had been employed in the institution:

We do appraisals every year generally, once you have been within the school for over three years, I think we then do it every two years, but that's at the choice of the member of staff. (Academic 3)

One interviewee (Academic 2) reported that the appraisals would occur two times per year rather than having just one annual appraisal as with the other schools of pharmacy that were interviewed.

4.3 Areas covered in the appraisal process

The interviewees described the different issues that were covered in an appraisal of academic staff. Each school of pharmacy had a similar purpose for appraisal which was generally to have open discussions on personal and career development. For example, within one school of pharmacy, the main aims of the appraisal were to review the past year, provide feedback, identify success and learn from problems encountered. There were also aims to set future goals, and to take into consideration the objectives of the department and other departmental colleagues. The following statements illustrate the purpose of the appraisal within this school of pharmacy and what it covers according to the head of pharmacy practice who is responsible for conducting appraisals for a number of individuals within their group:
I would say my personal focus is much more on career development and… and feedback, so a much softer approach to appraisals… and then sort of, an objective driven approach, although we do set objectives, it’s more of if people don’t achieve them, it’s more of a… a discussion around perhaps why objectives weren’t met, and there is no punitive, you know, action taken if somebody doesn’t achieve objectives, it’s more looking at their longer term role within the organisation and how we can, on both sides, try to fulfil that to make their job… increase their job satisfaction really. So that’s a little bit at odds I would say within some… to a certain extent the university’s view of what appraisals should be like. (Academic 1)

I use it [an appraisal] in the way that I feel is most appropriate for my staff, and I… I do use it much more in terms of career development and increasing job satisfaction than necessarily meeting targets, and certainly not in terms of performance-related pay. (Academic 1)

Following a similar purpose for appraisals, another interviewee commented on the way in which their institution’s appraisals once again serve to facilitate the development of the staff member being appraised:

I find that the way that we run the appraisals here are more useful because it’s focused on the developing individual whereas some of my colleagues elsewhere in pharmacy… some, not all and some at other schools it’s done as a tick box exercise to satisfying resources… you know it’s… some people don’t take it seriously and therefore they don’t find it as useful as I do as their Manager and as the individuals have said to me and head of school, that they find the appraisals really useful because it keeps them focused. It’s not intimidating to say, you know, ‘well I’d quite like to do this in a formal protected environment rather than sort of informally’, even though we keep in contact regularly it’s… there’s so many other things to talk about it’s a two hour protected time. (Academic 4)

Another interviewee stated that an appraisal was more of a ‘self-assessment’ and the appraisal system was not very useful at picking up issues of poor performance. There was however mention of picking up some performance-related issues of the job (e.g. teaching) through student evaluation forms:

[an appraisal] is a good way of… of planning ahead. I suppose one of the limitations… it only really looks at whoever it is being interviewed clearly over their perspectives on things… so if there are issues that they’re not so aware of, or don’t really have a handle on, they might not come up. I mean they might come up through different means through certain student evaluations and the teaching and things like that, but they might not formally come up through that [appraisal] process. (Academic 2)
The same interviewee also reported more information about their bi-annual appraisal, and what would be considered during each appraisal. It typically included identifying training needs and how to improve how they carry out their job:

[the appraisal] happens twice a year where a member of staff will meet with his or her line manager, and review objectives. At one meeting was...was reviewing performance against set objectives and set tasks that were set six months previously, and then at the next meeting was setting those for the next six months coming, so one’s retrospective and one’s prospective, to try and identify things like training needs, how they could be doing their job better, any issues that they feel that they've got, these sorts of things. (Academic 2)

As with the interviewee above, who mentioned that their institution's appraisals in place were almost a form of 'self assessment' and focused on development, the same focus was apparent within another school of pharmacy:

The staff fill in the [appraisal] form beforehand and then they email it to me, we arrange a meeting and then we go through...we just follow the pro-forma basically, but we discuss what their achievements have been, what things they need to develop and what things I can do to facilitate their development over the next year. (Academic 3)

We try not to use appraisals for performance as such we try and well if the staff themselves to identify the issues rather than me to identify them and then we talk around how we can then address them. (Academic 3)

One interviewee described how targets could be set for learning, teaching and research. There would also be targets that cover personal and professional development that form part of the appraisal:

[the appraisal] is around, you know, work priorities and targets within, sort of, learning and teaching and research and commercial consultancy, and that type of thing. Interestingly enough on the appraisal form there is a section which deals with personal and professional development targets...where it's about how individuals will keep up to date with skills, knowledge, etc., and how they would progress their career aspirations. So I guess, you know, it does mention the word 'professional' development, but because in universities as you've quite rightly pointed out, not all staff are pharmacists. (Academic 5)

It is evident that the appraisals have a strong focus on the staff member as an individual and how they can progress in their field and career. The appraisals, according to staff within the schools of pharmacy that were interviewed appeared to
be quite relaxed in their approach in assessing staff members who could include pharmacists and non-pharmacists among them.

4.3.1 Appraisal documentation

Four out of the five interviewees from the schools of pharmacy that were interviewed provided the research team with the appraisal documentation from their school. The appraisal forms from all four schools of pharmacy covered the same areas: a review of last year's objectives, a plan for the following year's objectives, identifying training needs, and commenting on anything pertinent to the individual which could be addressed by the appraisee or head/dean of school. The objectives were set out to cover the areas in which the appraisee worked (e.g. research; teaching) and allowed the appraisee to disclose which objectives were achieved and what objectives could be set for the following year. Some examples of objectives (provided by Academic 3) included “curriculum design” and “increasing student participation in large classes” for “teaching and learning” objectives; and “preparing research proposals” and “writing up research publications” for “research” objectives. The appraisal documents did appear to be a form of self-assessment whereby individuals could provide information about their activities over the following year as well future aims and training/development needs without having specific targets to meet laid out for them. Although the objectives within the appraisal focused specifically on the appraisee’s progress and aims, some of the appraisal documents (Academic 1 and 3) reminded appraisees to consider the objectives of the department as well as their own when making plans for future endeavours.

4.4 Appraisals and their use for revalidation

With regards to the revalidation of pharmacists within academia, and the potential use of appraisals for this process, there were some mixed views and indeed some ambiguity surrounding how a pharmacist in academia could be revalidated. Interviewees shared their opinions on the contributory role of appraisals towards revalidation and their views on the dilemma that may arise when attempting to appraise academic pharmacists.
Some interviewees noted that the appraisal was not necessarily useful for measuring performance-related issues, and if there were such issues they may best be identified by the individual who is being appraised:

“I’m not sure I find it [the appraisal] useful for assessing performance, I find it useful for having some dedicated time with each individual member of staff, to readily reflect on what they’re doing. I don’t think it’s a good way, necessarily, of assessing performance, and I…if I’ve got a new member of staff I’ll maybe do that in a different way, so that I…I’m interviewing them very frequently. With brand new members of staff we have interview them every three months…to look at their progress, and again, it’s against certain targets, you know, that they’re aware of the set up of the university, they’re aware of academic regulations, things like that, that they’ve attended set courses that they need to attend. (Academic 2)

We…as I say we try not to use appraisals for performance as such, we try and well if the staff themselves to identify the issues rather than me to identify them and then we talk around how we can then address them, so I suppose yeah if we had a member of staff who is not a natural teacher and that comes through on the feedback and they are desperate to do something about it so then I suppose we would discuss the different ways we could help them improve and get their feedback and you know improve the quality of what they are doing. (Academic 3)

The possible weaknesses of using an appraisal for revalidation were discussed in one instance, highlighting potential requisites for assessing fitness to practise, such as having an appropriate appraiser who could examine an appraisee’s performance regularly:

“I think if it’s [the appraisal] going to be [suitable for measuring fitness to practise] it has got to be by someone who is watching that person’s performance regularly and I suppose I can do that with my team because I do watch them regularly, but I think that might be one of the downfalls to our system where anybody can appraise anyone really as long as they are senior to them and therefore I suppose one improvement is this thing about do you need to know the person you are appraising and you need to see them in action regularly. (Academic 3)

It’s like communication skills and team working all those sort of general generic skills, those things that are important to be a good pharmacist can only really be accessed by someone watching you on a day to day performance. (Academic 3)

According to one interviewee, if the appraisal were to become a source of revalidation there may be a problem with the veracity of individuals’ self-reports:
A concern could be that if people knew that they had to meet some target or other as part of their appraisal in order to be revalidated, that they then would be honest at the appraisal, and I’d rather have the benefit of the honesty in terms of what they feel their strengths and weaknesses are as part of appraisal, and knowing that it didn’t directly link with revalidation. (Academic 1)

When Academic 1 was asked whether there may be potential for the abuse of the appraisal system for revalidation purposes such that an individual may not be truthful about their competencies, they replied:

Yeah. Yes, I suppose I would and I…and I would prefer to keep appraisal for what I use it for, for career development, as opposed to meeting some performance-related standard. (Academic 1, p.3)

When asked how appraisals could be used as part of the revalidation process some conceded that they did perhaps feed into the process, but most believed that appraisals alone would not be suitable for revalidation. For example, one interviewee commented:

Well I think revalidation needs to have two elements, one an assessment of safety as a practitioner and two an assessment of engagement or within these two to develop, I suppose, and continues to develop as a professional. So the second element, I think, is probably where an appraisal would fit in, so you know sitting down with someone looking at their CPD, looking at their education needs over the next year, looking at where they are engaging with that or whether they are just doing the same thing over and over again, I think you know, the appraisal could be quite useful. (Academic 3)

Some opinions on revalidation and the appropriateness of having more than just appraisals for revalidation were discussed by one interviewee:

I think it is an important part of it, some form of mentoring appraisal [to be] part of the process, and that’s quite important because there are certain things that you just cannot assess objectively, you know, you know…it’s like communication skills and team working all those sort of general generic skills, those things that are important to be a good pharmacist can only really be assessed by someone watching you on a day to day performance, and so therefore your appraisal as you are describing, would be a sensible way forward for that, but I think for […] clinical decision making…whether you are giving patients the right advice and looking at things and making the right decision […] some way of assessing that is important as well. (Academic 3)
The issue of appraisals for academic pharmacists in non patient-facing roles was discussed, and how the fitness to practise issues of an academic pharmacist can be appropriately assessed, for example, through teaching and research:

*I would say the way that we do it [an appraisal], it is appropriate to establish fitness for practise for an academic…and that would include an academic pharmacist. There are additional issues in terms of if they’re teaching on a particular topic that, that they use…if they’re teaching say the treatment of hypertension that they’re aware of the current guidelines on the treatment of hypertension but what we don’t step into if they do practise as in the community for example then in terms of the appraisal because that’s not part of their role then I don’t assess their fitness to practise to be a community pharmacist on a Saturday for example. (Academic 4)*

Another interviewee noted that some staff in a school of pharmacy may not be pharmacists. Fitness to practise may be less important if staff are not ‘patient-facing’:

*I suppose it depends in how you would define fitness to practise because a lot of the academic staff here wouldn’t actually be pharmacists. So urm wouldn’t really fall within, you know, causing harm to patients. All of my staff are pharmacists - oh except one - and a few that are scientists and have promotion experts who are the pharmacists. [...] I’m not sure when you know at the end of the day you know if somebody is not teaching properly will it cause harm to patients? I’m not sure, I think it would again depend on an extreme case to put [to a] fitness to practise issue. (Academic 2)*

In academia the roles held by staff can vary a lot, so any appraisal that contributes towards revalidation needs to consider these discrepancies in job roles:

*[…] the job can be so varied from you know a completely teaching job to a completely research job and then lots and lots of things in between. I suppose you have to be effective at what you do so depending on what you do might alter that and the outcome measured, so if you are a member of the teaching staff we have to say that you are teaching is up to date, that the teaching methods are effective, that you should benefit from what you are doing. I can see that is going to be really, really difficult to measure. (Academic 2)*

One academic reported that they felt fit to practise in their own right and that it may not be appropriate for the university to assess them on their ability to practise as a locum in community pharmacy:

*Well is it appropriate that the university were to assess my ability to practise in community? I have to do CPD and I…myself, I consider myself fit to practise in the community pharmacy where I work. (Academic 4)*
Although Academic 4 believed they were fit to practise in community pharmacy, there may be issues with not having appropriate supervision to verify these self-beliefs. The issue of pharmacists being isolated and working without close monitoring was an issue noted by one interviewee:

>You know, there’s certain areas where people are working in isolation and therefore no one is watching them perform and no one has any idea of the quality of information they’re giving and the quality of advice, but then you know, even in large institutes we can hide people who aren’t very effective as well, so, I think it would be wrong to sort of, you know, select a certain group, say you’re who we need to focus on, but, you know, by the nature of working as an independent pharmacist you’re someone who has no pressure to continually update, to continually engage or to review your practice ’cos you haven’t got a line manager. (Academic 3)

There was discussion surrounding the potential use of appraisals that may aid the process of revalidation, but alone, appraisals were not considered a tool that could be used for revalidation. The difficulties in revalidating pharmacists in academia were mentioned by some interviewees as well. Their role may be more focused on teaching and research as opposed to being patient-facing and therefore defining and assessing the fitness to practise of an individual with this job role would be dissimilar to a pharmacist in, for example, a community or hospital pharmacy.

4.5 Summary and discussion

All interviewees from the schools of pharmacy had an appraisal system in place for staff within their organisation. However, some interviewees pointed out that appraisal systems did not cover some part time staff (teacher practitioners). The appraisal systems in place within the schools of pharmacy were used as a way to chart career and personal development. Appraisals appeared to be similar processes within all of the schools of pharmacy and all staff members seemed to undergo a similar process of evaluation regardless of whether they were a pharmacist or not. Appraisals of pharmacists could also be undertaken by individuals who were non-pharmacists and, in some cases, may be carried out by people with little knowledge of the job role of the staff member they are appraising. They did not appear to be a rigorous process, nor did they seem to tap into fitness to practise issues of pharmacists which could be used towards their revalidation – at least not by
themselves. The ambiguity of fitness to practise within academia was discussed by some interviewees, and it is clear that the fitness to practise of those pharmacists in academia may differ to those pharmacists who are patient-facing.
5 Appraisal systems within Primary Care Trusts and NHS acute hospitals / hospital trusts in England

5.1 Introduction

This report is based on data that were collected through a project commissioned by the National Clinical Assessment Service (NCAS) concerning poor performance of pharmacists. The Centre for Pharmacy Workforce Studies at The University of Manchester was commissioned to undertake this research which investigated existing arrangements for identifying and managing performance concerns in pharmacists and the provision of training and education for remediation. The NCAS project consisted of two parts. Firstly, a series of telephone interviews were conducted with representatives from regulatory and professional organisations, locum agencies, community pharmacy employers and postgraduate training providers. The second part of the study used the findings from the qualitative interviews to design a series of postal surveys, which were sent to primary care organisations (PCOs) and NHS acute trusts/hospitals throughout the UK. The data from these surveys form the basis of this report on appraisal systems within these organisations. Although the NCAS project considered PCOs and NHS acute trusts / hospitals in the UK, this report only examines data obtained from England which, incidentally, represents the vast majority of respondents.

5.2 Method

5.2.1 Questionnaire design and distribution

The questionnaire consisted of two parts. Part one, pertinent to the NCAS project, contained a series of statements relating to pharmacists’ behaviour, which respondents were asked to rate. It also contained questions about how the PCO became aware of performance concerns, and about provisions of in-house training. Part two, relevant to the RPSGB project, asked respondents about the appraisal systems in place within their organisation (see Appendix 4 and Appendix 5, for PCOs and hospitals/ hospital trusts, respectively). Questions included who (pharmacists/
pharmacy technicians) were covered by the appraisal system, how often appraisals were conducted, and how the current appraisal system could be adapted for the purpose of revalidation.

5.2.1.1 Survey of PCOs

The questionnaires were initially sent by post in late 2009 to clinical governance leads in all 178 PCOs in England (n=152), Wales (n=7), Scotland (n=15) and Northern Ireland (n=4). A postal reminder survey was sent four weeks after the initial survey to all non-responding governance leads. In order to improve the response rate further, the non-responding PCOs in England were contacted by telephone in order to obtain the name and contact details of either the medicines management leads or the clinical governance leads. Subsequently the leads were either emailed or mailed another survey for completion ten weeks after the initial survey mail out.

The PCO survey was completed by 69 clinical governance leads. Sixty-seven respondents were from English PCTs and two from Scottish PCOs. The response rate was thus 44% for England, 13% for Scotland and 0% for Wales and Northern Ireland and 39% overall. This report considers the 67 respondents from PCTs from England. It was agreed with the RSC to only present the results obtained from England as the response rates from Scotland, Wales and Northern Ireland were poor. Thus, including results from these countries would not depict an accurate reflection of the true figures from the PCOs located there.

5.2.1.2 Survey of NHS acute hospitals / hospital trusts

The postal questionnaires for NHS acute hospitals / hospital trusts were initially sent in late 2009 to clinical governance leads in 50% of acute hospitals, excluding community and mental health trusts, in England (n=85), Wales (n=10), Scotland (n=23) and Northern Ireland (n=10). A postal reminder survey was sent to all the non-responding clinical governance leads four weeks after the initial questionnaire was sent. In order to improve the response rate, the survey was again mailed to the chief of pharmacist of all the non-responding trusts in England, ten weeks after the initial survey mail out.
In total, 32 hospital trust questionnaires were returned – 28 from England, 3 from Scotland and 1 from Northern Ireland. This gave a response rate of 33% for England, 13% for Scotland, 10% for Northern Ireland and 0% for Wales, and a total of 25% overall. Again, this report considers the 28 respondents from NHS hospital trusts in England.

5.2.2 Data Analysis
The survey data concerning appraisal systems were analysed using SPSS software. No statistical comparisons between PCTs and NHS hospital trusts were carried out due to small sample sizes. Frequencies and percentage of the data were obtained and are provided in the following results section.

5.3 Results
This section provides the results from the analyses of all of the questions answered by respondents that were relevant to appraisal systems (i.e. part two of the questionnaire). Within each table PCTs and NHS acute hospital trusts are compared alongside each other for a range of questions. Percentages and numbers (in parentheses) of respondents are provided for each response type.

5.3.1 Appraisal systems currently in place
The first question concerning appraisals asked respondents to select whether appraisal systems were currently in place within their organisation. This could be only for pharmacists, for pharmacists and pharmacy technicians, or neither for pharmacists or pharmacy technicians. Responses are summarised below in Table 8.

It is evident that most PCTs (~80%) have an appraisal system in place though it varies whether or not pharmacists alone, or both pharmacists and pharmacy technicians are appraised. Approximately one fifth (19.4%) of respondents from PCTs reported they did not have an appraisal system in place. This is in stark
contrast with the respondents from the NHS hospital trusts, who all have an appraisal system in place for both pharmacists and pharmacy technicians.

Table 8: Appraisal systems in place for PCTs and NHS hospital trusts

<table>
<thead>
<tr>
<th></th>
<th>PCTs (n)</th>
<th>hospital trusts (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only for pharmacists</td>
<td>29.9 (20)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>For pharmacists and pharmacy technicians</td>
<td>49.3 (33)</td>
<td>100 (28)</td>
</tr>
<tr>
<td>Neither for pharmacists or pharmacy technicians</td>
<td>19.4 (13)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>98.5 (66)*</td>
<td>100 (28)</td>
</tr>
</tbody>
</table>

* 1 respondent did not provide an answer

The following analyses (section 5.3.2 – 5.3.6) will only examine those respondents from PCTs and NHS hospital trusts who reported they did have an appraisal system in place, either for pharmacists or for pharmacists and pharmacy technicians. Therefore 53 respondents from PCTs and all 28 respondents from NHS hospital trusts are considered.

5.3.2 Who conducts the appraisal

Respondents were asked to report who is responsible for conducting the appraisals of pharmacists and pharmacy technicians within their organisation. Results for this section of the questionnaire are displayed in Table 9.

Table 9: The individual responsible for conducting the appraisals

<table>
<thead>
<tr>
<th></th>
<th>PCTs (n)</th>
<th>hospital trusts (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line manager</td>
<td>100 (53)</td>
<td>100 (28)</td>
</tr>
<tr>
<td>Clinical governance lead</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100 (53)</td>
<td>100 (0)</td>
</tr>
</tbody>
</table>
It appears that line managers within PCTs and NHS hospital trusts are generally the ones responsible for conducting the appraisals of pharmacists and pharmacy technicians.

5.3.3 How often are the appraisals conducted

Respondents were asked to state how often an appraisal would be conducted for pharmacists and pharmacy technicians. Results are provided in Table 10.

Table 10: Frequency of the appraisal

<table>
<thead>
<tr>
<th></th>
<th>PCTs</th>
<th>hospital trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>About every 6 months</td>
<td>1.5 (1)</td>
<td>21.4 (6)</td>
</tr>
<tr>
<td>About every 12 months</td>
<td>94.3 (50)</td>
<td>71.4 (20)</td>
</tr>
<tr>
<td>In response to an incident or complaint</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Other</td>
<td>3.0 (2)</td>
<td>7.1 (2)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100 (53)</td>
<td>100 (28)</td>
</tr>
</tbody>
</table>

The vast majority of respondents from PCTs and NHS hospital trusts reported that their organisation conducted appraisals every 12 months. A small number of respondents from PCTs (n=1) and NHS hospital trusts (n=2) noted – by adding remarks in the ‘other’ response field – that in addition to this annual appraisal, a review would be conducted every six months. Six respondents from NHS hospital trusts reported that appraisals were conducted more frequently, i.e. every 6 months. ‘Other’ responses provided by both groups of respondents were generally due to appraisals being conducted less frequently, such as every 18-24 months.

5.3.4 What is contained / discussed in the appraisal

Respondents were asked to consider whether a number of issues were contained and / or discussed within the appraisal (listed in the left hand column of table 4). Respondents were asked to tick all options that apply to their appraisal system. They also had the option of providing a brief description of other details discussed within
the appraisal system (i.e. ‘other’ responses). Table 11 displays the proportion of respondents who ticked the boxes for this question; i.e. acknowledging these topics were covered within their organisation’s appraisal system.

### Table 11: What is contained / discussed in the appraisal

<table>
<thead>
<tr>
<th></th>
<th>PCTs</th>
<th>hospital trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review of progress on personal development plan since last appraisal</strong></td>
<td>98 (52)</td>
<td>100 (28)</td>
</tr>
<tr>
<td><strong>Review of CPD log / record</strong></td>
<td>47 (25)</td>
<td>86 (24)</td>
</tr>
<tr>
<td><strong>Knowledge Skills Framework</strong></td>
<td>n/a*</td>
<td>89 (25)</td>
</tr>
<tr>
<td><strong>Performance</strong></td>
<td>94 (50)</td>
<td>97 (27)</td>
</tr>
<tr>
<td><strong>Identification of learning and development needs</strong></td>
<td>96 (51)</td>
<td>100 (28)</td>
</tr>
<tr>
<td><strong>Agreement on personal development plan</strong></td>
<td>98 (52)</td>
<td>100 (28)</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>9.4 (5)</td>
<td>14.3 (4)</td>
</tr>
</tbody>
</table>

* questionnaires for PCOs did not contain this option

Reviewing the progress on the personal development plan of pharmacists/ pharmacy technicians was almost always contained within the appraisal as stated by respondents, as was reviewing their performance, identifying their learning and development needs, and agreeing their personal development plans. A review of the appraisee’s CPD log / record was also a part of the appraisal of pharmacists and pharmacy technicians within the majority (~86%) of NHS hospital trusts. However, this was not routine practice amongst the PCTs that were surveyed; less than 50% stated that the appraisee’s CPD log/ record was reviewed. Within NHS hospital trusts, the knowledge skills framework was usually incorporated within an appraisal as well.

‘Other’ responses were provided by PCT respondents on five occasions. Some respondents commented that objective setting was contained in the appraisal (n=3), one respondent stated that meeting the requirements of the job description was contained, and one respondent declared that ‘non-work issues’ were discussed in the
appraisal. ‘Other’ responses were provided by NHS hospital trusts on four occasions. These respondents made similar comments – that objective setting / reviewing was carried out. One respondent stated that the knowledge skills framework was used as evidence only.

5.3.5 Adaptability of current appraisal for revalidation purposes

Respondents were asked to consider how adaptable they thought their current appraisal system was for revalidation purposes in the future. A five-point scale ranging from ‘not at all adaptable’ (1) to ‘very adaptable’ (5) was used to enable respondents to report the level of adaptability their appraisal system had for a revalidation process. The data obtained from this section of the questionnaire is found in Table 12.

Table 12: How adaptable the current appraisal system is for revalidation

<table>
<thead>
<tr>
<th></th>
<th>PCTs</th>
<th>hospital trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>% (n)</td>
<td>% (n)</td>
<td></td>
</tr>
<tr>
<td>1 (not at all adaptable)</td>
<td>15 (8)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>2</td>
<td>14 (7)</td>
<td>12 (3)</td>
</tr>
<tr>
<td>3</td>
<td>25 (13)</td>
<td>23 (6)</td>
</tr>
<tr>
<td>4</td>
<td>33 (17)</td>
<td>38 (10)</td>
</tr>
<tr>
<td>5 (very adaptable)</td>
<td>13 (7)</td>
<td>27 (7)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100 (52)</strong>*</td>
<td><strong>100 (26)</strong></td>
</tr>
</tbody>
</table>

* 1 respondent did not provide an answer
# 2 respondents did not provide an answer

Almost one quarter of respondents from PCTs and NHS hospital trusts that provided responses rated the adaptability of their current appraisal for revalidation purposes mid-range. Within PCTs, more respondents (~45%) responded with a ‘4’ or ‘5’ rating suggesting their current appraisal system was adaptable to some extent or very adaptable. Approximately 28% of respondents did not see their current appraisal system as adaptable (responding with ‘1’ or ‘2’). The majority (~61%) of respondents
from NHS hospital trusts indicated that their current appraisal system was adaptable, providing responses of either ‘4’ or ‘5’. Only 10.7% of respondents from this sector reported that their current appraisal system was not that adaptable for revalidation purposes, though these responses were given as a ‘2’ rather than a ‘1’, suggesting there may be some elements of the appraisal system that can be adapted as opposed to it being ‘not at all adaptable.’

5.3.6 Feelings towards incorporating additional questions into appraisal for the purpose of revalidation

One question within the questionnaire asked respondents to consider how they may feel about incorporating additional questions into their appraisal systems for the purpose of revalidation. Respondents could rate their concerns, ranging from ‘no concerns’ to ‘major concerns’. The data obtained from this section of the questionnaire is found in the following Table 13.

<table>
<thead>
<tr>
<th></th>
<th>PCTs</th>
<th>hospital trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>% (n)</td>
</tr>
<tr>
<td>No concerns</td>
<td>40 (21)</td>
<td>50 (13)</td>
</tr>
<tr>
<td>Minor concerns</td>
<td>25 (13)</td>
<td>19 (5)</td>
</tr>
<tr>
<td>Moderate concerns</td>
<td>23 (12)</td>
<td>16 (4)</td>
</tr>
<tr>
<td>Major concerns</td>
<td>12 (6)</td>
<td>15 (4)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100 (52)*</td>
<td>100 (26)#</td>
</tr>
</tbody>
</table>

* 1 respondent did not provide an answer
# 2 respondents did not provide an answer

The response type that received the highest percentage of respondents’ selections from both PCTs and NHS hospital trusts was ‘no concerns’. This suggests that a reasonably large number of respondents would not be concerned about incorporating additional questions into their appraisal system for revalidation purposes. A smaller proportion of respondents noted that they had minor or moderate concerns with these proposals than having major concerns. The least amount of respondents from PCTs (<15%) indicated that they held ‘major concerns’ with this proposal. When considering respondents from NHS hospital trusts, there
were the same amount of respondents (14.3%; n=4) who had moderate concerns as there were respondents who had major concerns.

5.3.7 General comments regarding the use of appraisal systems for the purpose of revalidation

The final section of the questionnaire allowed respondents to make any open comments about the use of appraisal systems for the purpose of revalidation. The following comments were made by respondents.

5.3.7.1 Primary Care Trusts

A total of 45.3% (n=24) respondents representing PCTs provided comments. The following comments were supplied by respondents:

- revalidation should be comprehensive: looking at a broader range of fitness to practise issues such as clinical skills and CPD relevant to job role (n=6)
- revalidation needs to address the issue of some pharmacy staff being appraised by non-pharmacists (n=4)
- whether revalidation and appraisal processes should be linked (n=2) or kept separate (n=4)
- not being aware of who would be responsible for conducting revalidation assessments and what form of training would be provisioned (n=2)
- the appraisal current appraisal process is not appropriate for a revalidation assessment (n=2)
- revalidation is ‘much needed’ (n=1)
- there may be negative biases in revalidation outcomes if an individual has a poor relationship with their appraiser (n=1)
- wanting to know how much extra time revalidation processes would take (n=1)
- how robust appraisal documentation would need to be for revalidation considering it may be produced by a pharmacist (n=1)
A number of respondents shared similar views on revalidation when they were given the opportunity to comment about the use of appraisal systems for the purpose of revalidation. Several respondents from PCTs reported that revalidation would have to be comprehensive in order to cover a broad range of skills necessary to demonstrate fitness to practise. The issue of some pharmacy staff being appraised by non-pharmacists was another issue raised on four occasions. Another comment raised by more than one respondent was the issue of whether or not the appraisal and revalidation process should be kept separate or tied together. The opinions of this were divided, though more suggested these processes should be kept separate.

5.3.7.2 NHS hospital trusts

From the 28 respondents representing NHS hospital trusts, 50% (n=14) provided comments. The following comments were supplied by respondents:

- lacking sufficient time and of staff could be a problem as appraisals consume enough time as it is (n=3)
- the appraiser would need to be appropriate and qualified to carry out appraisal (n=1)
- it makes sense to combine appraisals and revalidation (n=1)
- not knowing enough to comment (n=1)
- consistency with the appraisals as appraisers across different sectors may have different expectations for the individuals they assess (n=1)
- revalidation may interfere with open discussion of personal development between appraisers and appraisees (n=1)
- revalidation not thought to be a problem as a competency based self-directed package is in place for pre-registration pharmacists and pharmacy technicians (n=1)
- the present system is not designed for professional revalidation (n=1)
• modification of the RPSGB continuing professional development (CPD) would be preferred approach to revalidation (n=1)

• the appraisal system is about a performance review as opposed to performance monitoring, and the proposed change of focus is an issue (n=1)

• revalidation needs a combination of approaches to ensure it covers all aspects of the job (n=1)

• additional questions discussed during a revalidation assessment would have to be in the context of a pharmacist’s practice; it may not be practical for a regulator to be involved if they have little or no understanding of hospital-based practice (n=1)

• there should not be too much reliance on appraisals, as issues / concerns with individuals should be raised during the year (n=1)

• as with appraisals, revalidation would be useful way of addressing issues / concerns (n=1)

There were a number of different comments provided by respondents from hospital trusts. Most comments were raised by only one respondent, apart from the issue of how much time revalidation could potentially consume, which was a potential concern for three respondents.

5.4 Summary and discussion

The results of this part of the study have illustrated some of the similarities and differences existing between the appraisal systems in places within PCTs and NHS hospital trusts within England. Firstly, based on the findings of this research, it appears that there may be a prevalent framework for appraisals in place across NHS hospital trusts as all respondents from these organisations had an appraisal system in place for pharmacists and pharmacy technicians. There is less consistency amongst PCTs - only approximately 50% of respondents pointed out that there was an appraisal system in place for pharmacists and pharmacy technicians within their organisation. A further 30% reported there was an appraisal system in place, but
only for pharmacists. Some pharmacists – and even more pharmacy technicians – may therefore go un-appraised within some PCTs in England depending on the organisation they are working for.

All respondents from the PCTs and NHS hospital trusts surveyed stated that the ‘line manager’ was responsible for conducting the appraisal of the pharmacist or pharmacy technician as opposed to other roles such as the clinical governance lead. It is not known if the line managers responsible for conducting these appraisals were pharmacy professionals, or if it was considered important that they were. Based on some comments (section 3.7: Primary Care Trusts) there are instances where a pharmacist or pharmacy technician is appraised by a non-pharmacist which may be an issue for revalidation. Respondents also reported that is most common for appraisals to be carried out on an annual basis as most respondents pointed out out.

Differences between the appraisal systems of PCTs and hospital trusts emerged when examining what is contained / discussed within the appraisal. The review of an appraisee’s CPD log / record is something that the majority of respondents from NHS acute hospital trusts (85.7%) stated was carried out. Conversely within PCTs only 47.2% reported this was contained within the appraisal. There were more similarities between PCTs and NHS hospital trusts concerning other areas of the appraisal that were considered such as examining performance and identifying learning and development needs as most respondents from both types of organisation indicated were contained / discussed within their appraisal system.

Respondents from PCTs and NHS hospital trusts had similar responses concerning the adaptability of their organisation’s appraisal system to feed into the revalidation process. In general there were more respondents that thought their appraisal system was adaptable than not. This was particularly true for respondents from NHS acute hospitals / hospital trusts. Most respondents from both types of organisation were also relatively unconcerned with the proposal of incorporating additional questions into an appraisal for the purpose of revalidation. Some respondents did state they had moderate or major concerns but these individuals were outnumbered – approximately 2:1 – by those who held minor, or no, concerns.
Comments put forth by some respondents highlighted thoughts about appraisal systems and how revalidation could be incorporated into them. Although they varied between individuals, some comments were stated by several respondents – namely, what revalidation process would occur for those who may normally be appraised by non-pharmacists, or for those holding high positions (e.g. chief pharmacist / head of pharmacy). A number of comments were also made as to whether the appraisal system and a revalidation system could be merged or held in isolation. Comments about this issue were inconsistent and it appears some people may favour the processes being connected while others would rather them be kept separate. Lastly, there were concerns about how feasible it would be to carry out revalidation assessments in addition to carrying out other tasks such as appraisals due to having insufficient time.
6 A qualitative investigation of RPSGB Inspectorate and PCT contracts monitoring processes: Can they play a role in revalidation?

6.1 Introduction and method

The aim of this study part was to explore whether existing community pharmacy inspection and contracts monitoring processes could currently inform, or be developed to inform, revalidation processes for community pharmacists. Semi-structured qualitative interviews were conducted with a selection of personnel from the RPSGB Inspectorate and English PCTs. Seven interviews were conducted with RPSGB inspectors from each of the three regions, including the chief inspector, the three regional leads, and six with PCT personnel all directly involved in community pharmacy contract monitoring processes. PCTs were purposively selected to cover a range of localities (urban, semi-urban and rural) and, in each, a representative identified with experience of conducting contract monitoring visits.

All interviews were conducted by telephone and lasted between 20 and 50 minutes. Interviews were audio recorded with permission and transcribed verbatim. The qualitative data analysis software package NVIVO 8 was used to store and manage the data and assist with the data analysis process. The data were analysed thematically with themes initially being derived from the semi-structured interview schedules (Appendix 6 and Appendix 7) which guided the interviews and latterly from the data themselves.

The findings are presented in two parts: firstly the findings of interviews with representatives of the Inspectorate and latterly the findings of the interviews with PCT contract monitoring personnel. Each section is structured around:

- the functions of and processes currently undertaken by these organisations in relation to community (retail) pharmacies
- informants’ perceptions of the extent to which current procedures might inform revalidation processes for pharmacy professionals
• informants’ views of whether or not each organisation might play a future role in revalidation
• other sources of information which might contribute to revalidation
• issues pertinent to specific groups of community (retail) pharmacists.

6.2 RPSGB Inspectorate

The role of the RPSGB Inspectorate is twofold: firstly to conduct routine inspections of pharmacy premises and secondly to carry out investigations into complaints about pharmacists and pharmacy owners. There are currently 26 RPSGB inspectors covering Great Britain, most of whom are pharmacists. Pharmacy inspectors have responsibility for between 500 and 600 registered retail pharmacies, the large majority of which are community pharmacies. Inspectors are divided into three regional groups, each with a regional lead inspector:

They have two main core functions, one is to conduct routine visits, or monitoring visits to those premises to ensure there is compliance with standards and to look at any patient safety issues, and the other role is to investigate, on behalf of the society, any matters that have come to their attention as an allegation of someone’s fitness to practice is impaired. (Inspectorate 1)

6.2.1 Routine inspections of pharmacy premises

Each inspector conducts an inspection of each pharmacy premises at least once every three years (and more frequently when necessary). Pharmacies are informed of a visit in advance by letter and are asked to complete a self assessment prior to the visit. A standard format for inspection visits has been produced by the inspectorate and the associated documentation is available on their web pages. The areas covered by an inspection include controlled drugs monitoring (since 2007), storage of medicines, dispensing facilities, standard operating procedures (SOPs), training and continuing professional development (CPD), housekeeping, error reporting systems and the responsible pharmacist requirements. However, inspectors may focus their visit on particular issues according to what may be required for a particular pharmacy:
You sort of just do an initial risk assessment … just looking to see if there’s anything that stands out obviously and then depending on that, how you would focus the visit. … Obviously, at the moment, responsible pharmacist is probably something that I would talk about more because it’s only been in force since October. So obviously during the year as different things come up that you might probably focus your visit on so talk about a bit about responsible pharmacists but on the whole if, if people are complying and it’s not affected them too greatly then its not a lengthy conversation. (Inspectorate 7)

A report is produced after each visit indicating the areas inspected and identifying any areas of non-compliance and any improvements required. This is sent to the pharmacist and owner or superintendent pharmacist where appropriate. For any pharmacy premises not meeting the standards at an inspection visit, this report may be followed up by a second visit to ensure subsequent compliance and only in very serious cases will an investigation be opened. Inspectors stressed the supportive nature of their work with non-compliant pharmacies:

I’d probably revisit that pharmacy more often than usual to try and ensure that they’ve dealt with some of the matters which had been raised on the previous…recent visit. So it really means if required giving the pharmacy more attention and support. That would be the usual approach we’d have because its more effective and more productive for us, for the Society and for, I think, the owners or the pharmacists at the premises if we can deal with matters in that way. If we start heading more robust or formal ways of dealing with these then it’s going to be more costly in terms of time and money that the Society has really. So that’s usually the first port of call. It’s quite rare that…if a pharmacy is failing in quite a lot of standards… that we’d usually start an investigation or enquiry. (Inspectorate 5)

6.2.2 Complaints and investigations

The majority of complaints received by the Inspectorate are made by the public or patients but a number are also received from PCTs or GPs and occasionally from other pharmacists. Most complaints are as a result of dispensing errors made by the pharmacist, but the inspectors we spoke to had experience of dealing with complaints about advice-giving, pharmacists’ attitudes and behaviour, health issues, or more serious cases such as fraud:

I’ve worked as an inspector now for five years, and I’ve seen more or less all sorts of things I think. The main one we seem to get are dispensing errors, so that might be a dispensing error that the pharmacists have done themselves, then given out, so it's the kind of the pharmacist that's responsible. I had one where the pharmacist did an initial clinical check and then the dispensing technician’s checked it and obviously the technician bears responsibility for that. Other ones we’ve had, we’ve had
pharmacists who are drunk, pharmacists dancing in the dispensary, doing Kung Fu kicks in the dispensary, singing loudly, we've got a case of fraud, we've got cases of sexual harassment, more or less everything you can think of really. (Inspectorate 6)

Complaints received undergo a form of ‘triage’ to determine whether they can be dealt with locally, whether they should be referred to the investigating committee or ultimately to the disciplinary committee. Less serious complaints may not warrant investigation and can be dealt with through correspondence with the complainant and pharmacist. For dispensing errors, one investigator describes the process thus:

*It could involve going to see the complainant, taking statements, taking any exhibits and then going to the pharmacy and speaking to the pharmacist, looking at their procedures and systems to see how the others can be prevented or minimised from happening in the future and to, to deal with and then reporting that back. (Inspectorate 7)*

More serious cases may involve the inspector liaising with a range of different agencies including the NHS Counter Fraud Service or the police and giving evidence to the Disciplinary Committee.

### 6.2.3 Potential involvement in revalidation processes

All interviewees were asked what they understood by the term ‘revalidation.’ Most knew that it was about being able to demonstrate one’s fitness-to-practise. Some were unsure about how to differentiate it from CPD whilst others recognised that it was more than that:

*It’s more than just showing that you’re keeping…it’s more than continuing professional development, it’s when you’re keeping up-to-date, it’s about are you actually…an assessment of, ‘are you actually still competent and fit-to-practise,’ and it’s being able to demonstrate that (Inspectorate 2)*

Interviewees were further questioned on whether information currently gathered through Inspectorate processes could feed into the revalidation process, whether their roles could be extended to incorporate aspects of revalidation, any barriers to the above, and what they thought a system of revalidation for pharmacists might involve.
6.2.3.1 Current roles

Interviewees were split as to whether or not current Inspectorate roles and the information they gathered could feed into a system of revalidation for pharmacists. Many highlighted the disparity between their current role of monitoring pharmacy systems and procedures as opposed to individual pharmacists’ performance:

_We’re not experts in performance. We can’t look at the activities of service provision by a practitioner, and say whether that performance is appropriate or not. We can look at services and service models and say whether they are compliant with national guidance or whether they are legislatively correct, but that’s a big difference between the individual act of a registrant._ (Inspectorate 1)

Others felt that knowledge of current legislation and quality of procedures might be a reflection of a professional’s performance. However, it was also recognised that the pharmacist on duty at the time of an inspection might vary, and could be a locum, making such a link between premises and person tenuous.

In relation to routine inspection visits, a small number of elements were identified which might provide an indication of performance and thus feed into the revalidation process including the pharmacist’s knowledge of current legislation, the level of training offered to and achieved by staff and the quality of SOPs, record-keeping and the premises itself.

A small number of examples were provided of instances when a pharmacist’s performance was called into question during a routine inspection visit. These included cases where a pharmacist was storing controlled drugs “routinely and in large quantities” outside the controlled drugs cabinet; one pharmacist who did not have any indemnity insurance; another where the premises was in a “complete and utter muddle.” However, the comment was made that a pharmacy’s systems and procedures would have to be operating at a very low level before the pharmacist’s performance would be called into question.

Other problems identified with incorporating current systems of inspection into processes of revalidation for pharmacists included the difficulty in targeting individuals and covering every pharmacist (related to the fact that inspections were of
premises not pharmacists); visits provided only a two hour “snapshot” of what went on in a pharmacy; and the fact that inspectors were not skilled in assessing clinical competence.

The bulk of the intelligence collected by inspectors concerning the performance of individual pharmacists is, however, through the complaints system or ‘hearsay’ as opposed to through routine inspections. Whilst some felt that this information could be used for revalidation purposes, it was recognised that it did not provide a good representation measure of performance for the majority of pharmacists (i.e. did not re-affirm fitness to practise as required for revalidation).

6.2.3.2 Future roles

A small number of interviewees could envisage that inspections could be developed to feed into a process of revalidation for pharmacists:

I suspect with resources that could be implemented or developed. I think it would be part...it could be, yes, subject to resources and obviously development in programme ... I don't think you could base the whole revalidation just on an inspector’s assessment, but I certainly think you could feed into the revalidation programme yes. (Inspectorate 3)

Others were adamant that their role was too far removed from providing assessments of individuals. However, interviewees were generally ambivalent as to whether or not the roles of inspectors could be extended to incorporate collecting evidence for revalidation purposes. A number of issues were raised that would have to be addressed in order for this to be possible. Many were concerned about the resource implications (both time and cost) of assessing every pharmacist on top of an already heavy caseload of pharmacy premises:

For there to be a meaningful cycle of events, re-validation events for the 45,000 registrants on the register, that’s a massive piece of work ... By all means, if they want to quadruple the number of inspectors we have, I'm more than happy, but there'll be massive cost implications. (Inspectorate 1)

Others mentioned the need for training to ensure that inspectors had the ability to assess clinical competence:
It would have a massive impact, absolutely massive impact, you know. Firstly there'd have to, we'd have to be trained properly to assess and I, I can't see how, I would have thought to do revalidation of say clinical competency would need someone who was in that same field. And you would need, you know, if you've got a community pharmacist, who needed revalidation, I don't think an inspector who hasn't practiced for maybe sort of fifteen years, would be the right person to do that revalidation. (Inspectorate 4)

Others suggested that information systems would need to be implemented or improved in order for the various strands of information from different sources to be collated about individuals.

6.2.4 Other sources of information for revalidation

Interviewees were asked to suggest what would be appropriate sources of information for revalidation purposes. Whilst a small number could not see past a CPD-type approach to revalidation, most believed that this would form but a small part of the revalidation process and that information should come from a wide variety of different sources:

I would have thought that for revalidation, you would be asking for evidence from different factions wouldn't you. You'd be asking for evidence from the regulator, to see if there was any fitness-to-practise issues; you'd be asking evidence from an employer because they have their appraisal systems in place; and you'd be asking evidence maybe from, on a contractual point, like from a primary care organisation as well ... I think the three hundred sixty degree approach would be the best. I mean even, now you have sort of like patient surveys don't you. (Inspectorate 4)

Most commonly, employers’ existing appraisal systems were seen as an important source of information but many also suggested that peer review or 360 degree appraisals should also form a part of the revalidation system. A smaller number could see the potential for observations as part of the revalidation process which could also collate existing information from PCT contract assessments, complaints and investigations and patient surveys. Whilst some form of exam or test was also suggested, doubt was expressed as to whether this would prove a reliable source of information.
A number of problems were identified with using and collating different sources of information for revalidation purposes. Many were concerned with the consistency and objectivity of the information collected, for example through appraisals, in order that the system was fair to all those being revalidated:

There is a lot of information out there; again its grading that information and how reliable that information is because it’s down to the objectivity and how its been done. But as long as there is some kind of grading system as to the reliance that’s placed on the information that’s received, I think you could take the information from as wide a sources as possible really. (Inspectorate 3)

Others recognised that there might be commercial sensitivities and that systems of data collection and transfer had to be transparent. If new assessment processes were implemented for revalidation, such as observations or exams, some highlighted the issue of the extra workload that would entail for pharmacy professionals and the possibility that it would take them away from their current work. The importance of adequate information systems was again highlighted.

### 6.2.5 Revalidation for different groups of pharmacists

Interviews also explored whether there were any inherent difficulties with revalidation for particular groups of pharmacy professionals, which groups the Inspectorate might be well-placed to take responsibility for, and whether or not any groups should be targeted. Whilst a small number of interviewees believed that a system of revalidation should apply to every pharmacy professional ("I think it’s got to be fair for everyone"), the majority believed that a targeted system, based on risk, would be preferable:

I think that’s absolutely paramount really. It’s got to be that way hasn’t it. I mean if you’re doing revalidation for the benefit of the public, you know so it improves patient safety and it improves the public’s confidence in pharmacy, it would be ridiculous just to start from alphabet A, going down, to revalidate pharmacists. Certainly there needs to be sort of a targeted approach. (Inspectorate 4)

A number of risk factors were suggested, including age, sector of employment and whether or not the pharmacy professional was in a patient-facing role, and also employment status. In particular, locums were singled out, not only in terms of being
a higher risk group but also because systems of revalidation would be harder to implement for locums:

_A lot of the locums move around all over the place. Some locums work at a different pharmacy every single day, and it's very hard I think to keep an eye on them and check they're practising okay, and see what they're doing. I mean, some locums are a lot better than others, and some will actually be quite good pharmacists, and I have seen some very, very bad locums, who just do it as a job and just don't care at all, and I don't know how you could catch... how you could make the bad ones improve really._ (Inspectorate 6)

Whilst some interviewees believed that the inspectorate would be well placed to take responsibility for locums, others thought that they would be too difficult for the Inspectorate to manage. However no-one suggested an alternative body, which might be better placed, and therefore there is a risk that locums could fall through the revalidation net.

Interviewees generally believed that the larger multiples should be responsible for undertaking the revalidation of their own employees, having the infrastructure already in place to support this process. Independent pharmacists, on the other hand, were thought to require more support and many interviewees thought that the Inspectorate might be best placed to take responsibility for this group and for superintendent pharmacists.

### 6.3 PCT contract monitoring personnel

Interviewees participating from English PCTs were usually primary care/ pharmacy commissioning or contracts managers, although one was a pharmaceutical services manager. They were either located in primary care commissioning directorates or else within medicines management teams. Those based in commissioning usually had close links with medicines management. All were directly involved in monitoring community pharmacy contracts in their locality and many also had a role in developing community pharmacy services in their area. Only two were pharmacists themselves.
I guess there’s two major strands to my role: there’s the managing of the current pharmacy contracts we have which encompasses ensuring that they’re compliant with you know core contracts or terms of service and the terms of any enhanced services we commission. And then the second part of the role is the kind of developmental aspect which again is two fold which is around identifying needs for and developing additional services or enhanced services through our pharmacy contractors (PCT2)

6.3.1 Contract monitoring processes

Whilst guidance is available to PCTs for community pharmacy contract monitoring processes, no standard format has been imposed and a range of documentation and processes have developed across England. Two PCTs involved in this study used the standard Community Pharmacy Assurance Framework (CPAF) available on the NHS Primary Care Commissioning website. Others, however, have developed their own sets of documentation and processes, sometimes a modification of the CPAF. In most cases, monitoring involved an element of self assessment. However, the degree to which self assessment formed the basis for contracts monitoring varied from one PCT to the next. For example, the CPAF and some other systems use self assessment as a precursor to a monitoring visit. In one PCT, however, self assessment had been the only form of monitoring and they were only beginning to undertake monitoring visits at the time of the interview. In another, annual visits had been conducted in the past with all local pharmacies and self assessment now being used to identify a 20% sample of the worst performers to subsequently visit.

The frequency of monitoring visits also varied between localities. These PCTs contracted with between 35 and 120 local pharmacies – each of which were visited generally on a two year or three year rolling programme. There were two exceptions to this, with one PCT only beginning to implement a visiting programme and one PCT moving to visiting only a 20% sample each year. The latter was a large urban PCT with 120 pharmacies in its locality. Not every interviewee was asked who, in addition to themselves, undertook assessment visits but it would appear that here too there is some variation. Some visits were being conducted solely by the contracts manager and others also involved a member of the medicines management team.

In a similar manner to the Inspectorate, following a contracts monitoring visit PCTs produced a report highlighting any areas of non compliance or where improvements
were needed. This may be followed either by further communication with the pharmacy contractor or subsequent visits to ensure that any problems have been addressed. As with the Inspectorate, PCT interviewees were keen to stress the supportive nature of their work with pharmacies in maintaining the standards of the services they delivered. They either preferred not to go down the punitive route or perceived that the PCT had very little powers with which to do so:

So you know what we try to avoid really I suppose initially is to you know wield any big sticks initially because I think you know we find we get more out of the relationship with the contractors if we can work with them to you know to try and address any shortfalls. (PCT5)

What we did find from scrutinising the contractual framework is that there was very little leeway for the PCT to act so its almost sort of making suggestions to the head office that they...there were things that they might want to do to improve the quality of the service but not much we could do in terms of remedial notices. (PCT3)

6.3.2 Areas covered in a PCT visit: A review of contracts monitoring documentation

The interviewees from four of the six PCTs supplied a number of documents which outlined what would be examined during a contracts monitoring visit. Some of these interviewees also provided an example of a self assessment form that would be filled in by the contractor before a visit. In addition, one further interviewee (from the PCT that was only beginning to undertake monitoring visits) provided documentation that was sent to contractors – information that would assist and support community pharmacists and their staff to meet the clinical governance aspects of the pharmacy contract.

The documents used during monitoring visits were similar across all PCTs. They each covered the essential services: dispensing, repeat dispensing, disposal of unwanted medicines, promotion of healthy lifestyle, signposting, support for self care, clinical governance, as well as the advanced service (medicine use review) outlined in the CPAF. The individual carrying out the contract monitoring visit would seek out evidence which supports the implementation and delivery of the services, generally this would be to ensure standard operating procedures (SOPs) were in place for each service.
The forms used by the PCTs for monitoring and grading the quality and delivery of the services differed – mainly in format – though they still appeared to cover the SOPs and other requirements laid out by the CPAF. The differences between the forms appeared to exist in order to compile the contract monitoring content in a manageable way. One PCT used a colour coded scheme to allocate points to pharmacies for visits and self assessments as a way of measuring performance across pharmacies uniformly.

The information requested from contractors in the self assessment forms was very similar to that sought during PCT visits. Questions on the self assessment form asked about the SOPs in place that serve to provide the essential and advanced services. These self assessment forms appeared to be based around those laid out in the NHS Primary Care Commissioning (NHS PCC) website, though they were generally less comprehensive and would require less time to fill in.

6.3.3 Other sources of information gathered by the PCT

As part of their contract with the PCT, community pharmacies have to provide evidence that they are conducting annual patient surveys and that they are recording and dealing appropriately with patient or customer complaints. Interviewees were asked about the information they receive for pharmacies in relation to patient surveys and customer complaints.

The information received by these PCTs from pharmacy contractors regarding patient surveys was generally patchy. Not every pharmacy returned information and the quality of those returns was variable. Some provided all the survey data and also information on the ways in which they were addressing areas in which they were not doing so well; others provided summary data only. The impression given by these PCTs was that they did not specify exactly what information they wanted to receive from contractors and that some did not appear to have any system in place for recording this information nor for acting upon it:
Some of them will send us absolutely everything, they’ll send us all the results and the action plan, but others will just supply us with the fact that they’ve done the required number and the fact that they’ve got an action plan and then the details of that action plan. So it tends to vary how much information we get back. But we get the fact that they’ve done it and what they need to do next. We inwardly digest it but we don’t do anything apart from that and then filing it. (PCT4)

PCTs received information about customer complaints through contracts monitoring procedures, via the Patient Advice and Liaison Service (PALS) or directly from the public or other health professionals. However, they did not deal with complaints to the same extent as the Inspectorate and may indeed refer complaints onto the Inspectorate. Information about complaints collected through contracts monitoring procedures, as with patient survey data, appeared to be patchy. PCTs sometimes used the data to support pharmacies in addressing areas where they received a large number of complaints or to ensure that they have adequate systems in place for dealing with complaints that they receive:

When we do our pharmacy visits we check the number of complaints that have been received if any and also the process that they have in place for those complaints and to make sure that if they’ve got consistent complaints on a particular item or a particular thing, then they are actually doing something about it rather than just saying, “Oh yeah we’ve got twenty two complaints and they were all about waiting times”. We want to make sure that if they have got several complaints on the same topic that actually something is done about it. (PCT4)

6.3.4 Potential involvement in revalidation processes

In general, PCT interviewees appeared to be less informed about revalidation than those from the Inspectorate, although this was unsurprising given that only two were pharmacists themselves. Most understood it concerned demonstrating a pharmacy professional’s fitness to practise and that it related in some way to CPD, but many clearly had not considered what it might entail or if, and how, the PCT should be involved:

To be honest I haven’t really picked up on the debate about revalidation so I don’t really know where it’s going. I mean I will assume it’s about ensuring that the contractors are up to date in their core competencies and core skills and are, you know, current and in line with current findings and current practice and recommendations, that’s what I assume it is. Beyond that I know very little about it. (PCT2)
As with the Inspectorate, PCT interviewees were further questioned on whether information currently gathered through contract monitoring processes could feed into the revalidation process, whether their roles could be extended to incorporate aspects of revalidation, any barriers to the above, and what they thought a system of revalidation for pharmacists might involve.

### 6.3.4.1 Current roles

Similarly to the RPSGB inspectors interviewed, PCT respondents raised doubts over the extent to which current contract monitoring processes could feed into a system of revalidation for pharmacy professionals. Like their Inspectorate counterparts, PCT interviewees were primarily concerned that they were monitoring aspects of the organisational delivery of the contract as opposed to the performance of individual pharmacists or pharmacy technicians:

*Our performance framework is focused more on the organisational delivery of a range of things that are covered within the contractual framework ... and not on individual performance.*  (PCT3)

In relation to this, visits were to a particular pharmacy and not arranged around an individual:

*Now in terms of looking at the pharmacist that to me becomes a minefield because the person that you're talking to perhaps on that contract visit that day may only be a locum in for the day or they might be there twice a week or once a month or, you know, its very difficult to pin pharmacists down.*  (PCT1)

Consequently, where PCT respondents did suggest that current contract monitoring processes might inform revalidation it was commonly at the organisational level, in particular whether or not pharmacies had systems in place for ensuring CPD and training of their staff:

*We tend to check that the pharmacists themselves are doing CPD and that they're entering the information and certainly that they're attending the courses that we need them to attend to provide any of our services but I don't know how much the other areas within the contract monitoring visit will actually tie in with something personal to that pharmacist.*  (PCT4)
A further issue apparent from interviews with contract monitoring personnel was linked to the fact that only a minority were themselves pharmacists. One interviewee (not a pharmacist) suggested that revalidation would need to be conducted by a qualified pharmacist:

_’I would see revalidation as being very much you know a set of skills and I think almost certainly you would need some pharmacy background in order to develop those skills.’ (PCT2)_

Another who was thus qualified agreed:

_’You walk into a dispensary and you know straight away whether or not it’s organised and whether or not it’s running smoothly just by looking around … as soon as you walk in you think, “Oh my god” and others you walk in and think, “Yeah, this looks…” cos you can see there’s organisation, there’s method and you can see the pharmacist checking that type of thing. And also in the conversations that you hear, you might pick up things and think, “What is that pharmacist saying to that patient?” or, “What’s going on there?” But that comes with being a pharmacist myself. Now whether somebody else going in as an outsider would know or understand I’m not sure.’ (PCT1)_

As a result, few instances of concerns with pharmacists’ performance had been encountered by these interviewees during their work. One was in relation to the pharmacist’s behaviour towards a patient:

_’We’ve had a, we’ve had an occasion…we’ve only had one that I can remember about inappropriate behaviour when inappropriate comments were made to a patient but they’re very few and far between when we get them.’ (PCT2)_

Another was a suspected case of fraud:

_’It was around an allegation that the patient was making that they had a list of medication, however they’d not always got all the medication on their list … I suppose kind of saying that, you know, is there some fraud going on? Whereas the GP was saying, well, we’ve been issuing all these medicines…’ (PCT6)_

Other instances were around overseas pharmacists not fully understanding the terms of the pharmacy contract and locum pharmacists not maintaining their competencies.
6.3.4.2 Future roles

Whilst PCT respondents found it difficult to envisage where current processes might feed into a system of revalidation for pharmacy professionals, most were supportive of a future role for PCTs in the process. Some believed it might be possible to build on existing contract monitoring processes to incorporate checks on the systems pharmacies had in place for the revalidation of their staff:

I can't see why not because in somewhat we're kind of doing it and if we are visiting to collect those...that information anyway it just saves somebody else doing it. (PCT6)

One interviewee suggested that PCTs may have an additional role in appraising pharmacists for revalidation in a similar way to which GPs are subject to appraisal for revalidation purposes:

Interviewee: The PCT...we are responsible for arranging and undertaking appraisals for GP's.  
Interviewer: And do you think that that kind of thing could be done for pharmacists and pharmacy technicians as well within the PCT?  
Interviewee: Yes, yes, yes. (PCT1)

Another believed that, whilst the PCT should not necessarily be responsible for undertaking revalidation procedures with pharmacy professionals, they needed to have a role in overseeing the process:

I think we would have to have some role in administration because obviously I'm assuming that revalidation would be a requirement and that they won't be able to practice without revalidation and therefore we'd need to have a hand in the process to know where people were within that process.  (PCT2)

Unsurprisingly, the need for additional resources was the most common obstacle raised to PCTs future involvement in revalidation for pharmacy professionals. However, this was put in the context of current cuts within the NHS raising doubts over whether any additional resource would be forthcoming:

How manageable that would be within PCTs without additional resource, I would say probably not. But there’s no reason why, if somebody said, “Well here’s the resource to be able to do it,” it couldn’t be done but I’m not sure…I certainly wouldn’t like to say on behalf of our PCT at the moment that’s reducing in size because of all the problems. (PCT5)
Interviewees also raised a potential conflict of interest should PCTs take on a role in revalidation:

*I suppose your relationship is bound to change slightly with the community pharmacists where we are trying to get the community pharmacist to be able to provide some wider services through enhanced services. I mean people will obviously, I mean they already feel uncomfortable when you go and do this sort of visit I think they’d probably feel a lot more uncomfortable and maybe not be as transparent as they are now.* (PCT6)

Other potential barriers to PCTs developing a role in revalidation included the need for qualified pharmacists to undertake this role; the absence of a performers list for pharmacists currently; the confidentiality of some of the information that might be collected for revalidation purposes; and what procedures would need to be put in place for pharmacists who did not meet the standards for revalidation.

### 6.3.5 Other sources of information for revalidation

Interviewees were asked to suggest other sources of information which might be appropriate for revalidation purposes and what a system of revalidation might involve. Most suggested that existing CPD records could form the basis for revalidation, although possibly only as part of a portfolio of evidence. Various suggestions were made for other elements of this, including appraisals, self assessment, information from patient surveys, and/or complaints and incidents.

*I think in terms of revalidation … information obviously from the pharmacists themselves in terms of what they’ve done during the sort of course of a year to maintain their own professional development … but you know other things [such as] local surveys on patients’ perceptions of services that are being provided … so some of that information may or may not be useful.* (PCT5)

The need for an external assessor to validate this portfolio of evidence was stressed by two out of the six interviewees, possibly a GP or other health professional or a panel. The time which would be needed for pharmacy professionals and any appraiser/ assessor to undertake these processes and collate the information required was again raised as a potential stumbling block. There was also some suggestion that pharmacists would not only find it difficult to find the time to
participate in such processes, but they may actively avoid it unless there was an incentive or a penalty for not doing so.

6.3.6 Revalidation for different groups of pharmacists

As with RPSGB Inspectors, these interviews explored whether there were any inherent difficulties with revalidation for particular groups of pharmacy professionals, which groups PCTs might be well-placed to take responsibility for, and whether or not any groups should be targeted. PCT respondents appeared less likely to support a targeted system of revalidation than their Inspectorate counterparts:

I think if we targeted particular groups, I think that that will cause problems in itself … no, no I don’t see that really. I think we would either have to do all or none. (PCT1)

Regarding particular groups of community pharmacists, these interviewees identified independent pharmacy owners as potentially facing the greatest problems with revalidation. This was in terms of their having the time and resources to participate in the process and also in relation to the support available to them:

I think your very small local independents [might be] problematic in so far as their capacity to, to…you know the time they’ve got…I mean we’ve got a number of pharmacies who are just…you know its one pharmacy owner, does everything, hasn’t time to do anything else its, its very limited for them. (PCT2)

I think the independents would find it hard definitely because what would happen if they went through this process and you found some glaring problems with them … where would they go really? They would need an awful lot of support in order to get them revalidated … so I see potential problems there. (PCT1)

As a result, some interviewees believed that PCTs would be best placed to take responsibility for the revalidation of independent pharmacy owners and/or to provide the support they might need to undertake revalidation. In contrast to this, multiples were generally seen to have a greater likelihood of being able to support systems of revalidation for their staff. However, one interviewee did identify a potential problem with overseeing the revalidation of pharmacists in multiples in terms of ensuring the quality of the assessment systems they had in place:
How would you examine the quality of what’s actually being done in terms of revalidation? I think there would have to be a very clear process and set of expectations in terms of what should happen, because I think it’s very easy for the multiples to be revalidating their own employees … you may not get as much out of it as perhaps you might do if it was being done externally and consistently by one organisation perhaps, you would get varying quality and varying arrangements possibly within the different companies (PCT5)

Locums were again identified as a potentially problematic group for revalidation. In addition to a number of issues with the performance of locums encountered by contract monitoring personnel, the transient and mobile nature of locum employment was suggested as hindering the revalidation process:

I think there’s a real issue about managing locums…cos there seems to be a lot of businesses that are run on the back of locums and I think well some of them might not want to take responsibility with monitoring those locums and whether they’ve achieved their revalidation. (PCT3)

They’re more difficult for us to keep a track of…we have an electronic database but its quite difficult to keep tabs on that information and making sure that the emails that they give us are the correct ones and they’re up to date and they’re actually accessing them. So we would need to have a better way of capturing that information so that we could actually keep…not keep tabs on them…but so that we were able to give them the right information when it’s needed. (PCT4)

6.4 Summary and conclusions

Qualitative interviews with a purposive sample of the RPSGB Inspectorate and PCT community pharmacy contract monitoring personnel have provided data to suggest that, whilst routine inspection/monitoring visits are conducted within community pharmacies, there are inherent difficulties in using any of the information collected for the purpose of revalidating individual pharmacy professionals.

RPSGB inspectors are responsible for conducting routine inspections of between 500 and 600 pharmacy premises each, at least once every three years. They are also tasked with conducting investigations into complaints about pharmacy professionals. Inspections focus on controlled drug monitoring, medicines storage, dispensing facilities, standard operating procedures (SOPs), training and CPD, housekeeping, error reporting systems and responsible pharmacist requirements. Most
investigations follow complaints about dispensing errors although others concerned the attitudes and behaviour of pharmacy professionals, health issues and more serious issues such as fraud. Whilst some inspectors believed that some of the information collected during inspection visits might be indicative of a pharmacist’s fitness to practise, in particular in the case of independent pharmacy owners, it was commonly stated that inspections related to premises and not to individual pharmacists, making such a connection difficult at best. A small number of interviewees could envisage that the current system of inspections could be developed to contribute to the wider revalidation process but most were concerned about the resource implications of such a move. Many inspectors were in favour of a targeted system of revalidation based on risk.

From the interviews with PCT contracts monitoring personnel, it was apparent that wide variation exists in the structures and processes developed by PCTs to monitor community pharmacy contracts. The PCTs we spoke to were responsible for monitoring the contracts of between 30 and 120 community pharmacies and used a variety of processes for self assessments and visits with differing frequencies and methods for targeting. The areas covered by contract monitoring processes included monitoring essential and advanced service provision, and enhanced and local services where these were commissioned. PCTs also received patchy evidence of annual patient surveys and customer complaints through their monitoring processes. It was commonly believed that the data collected by contract monitoring processes could not be used for revalidation purposes as it related to organisations and services and not to individual pharmacy professionals. Some suggested that PCTs could develop a future role in the quality assurance of employers’ systems of assessing staff for revalidation purposes or directly in the revalidation of independent pharmacy owners.

In summary, inspection and contract monitoring data currently have little or no utility in the revalidation of individual pharmacy professionals. There may be potential for the Inspectorate and/or PCTs to develop a role in the revalidation of locum and/or independent pharmacists. They may also have a role in providing some of the infrastructure required to support the overall process or framework for revalidation.
7 Appendices

Appendix 1: Interview topic guides – community pharmacy stakeholders

Do pharmacy technicians within your organisation receive appraisals?

Who conducts the appraisal? Are they a practising pharmacist?
Does the appraisal cover a range of clinical and professional-related duties for a pharmacy technician should be equipped with or is there more of focus on business-related issues for the organisation?
Would it be suitable for the revalidation of a pharmacy technicians FTP for revalidation in the future?

Moving on to pharmacists…
Can you outline the infrastructure of the different pharmacist positions there are within your organisation, starting from those below the pharmacy manager through to you as the superintendent?

Do all of these pharmacists receive an appraisal?
Who is in charge of the appraisals of these individuals, starting from those positioned below the pharmacy manager
Are the people in charge of appraising pharmacists practising pharmacist themselves?
Can you outline what is covered in these appraisals and highlight some of the similarities and differences between what is covered for these individuals’ appraisals? E.g. are there differences between professional/clinical monitoring between staff?; differences for business targets/performance?
What are the business, professional and clinical aspects you look at, can you give some examples?
Are any of these appraisals particularly useful or contributory to assessing a pharmacist’s fitness to practise for revalidation? None?
Are all pharmacists’ appraisals quite different to pharmacy technicians?
Do you believe there may be difficulties in having a pharmacist within your organisation appraising another pharmacist's skills and challenging their abilities? *For example a pharmacy manager assessing their colleague pharmacists.*

Do you as superintendent feel responsible for the fitness to practise of your pharmacy staff?  
Who do you think should be responsible for such issues – ensuring the pharmacy staff within the organisation are fit to practise?

Do you as superintendent receive an appraisal?  
Who (if so) conducts this appraisal? How often? What does it cover?  
Do you think you should be appraised (if not)?

[Can you send any documentation about the appraisals within your organisation?]
Appendix 2: Pharmaceutical Industry Interview guide

[Would it be possible to have a copy of the appraisal documentation used?]

Can you give me a brief description of your role?

Does your organisation currently have an appraisal system which is used for pharmacists and/or pharmacy technicians working in your organisation (for example personal/ performance development review, performance monitoring)?

If the organisation does not have an appraisal system in place:

Do you think your organisation should have an appraisal system in place?
Who should conduct these? (internal or external; pharmacist or other role; training necessary)
How should it be conducted?
Do you think it would be possible to incorporate issues relevant to the revalidation of pharmacists/pharmacy technicians into a system of appraisal?

Do you have any other systems in place which measure the performance of pharmacists/pharmacy technicians and might be incorporated into the revalidation process?
  - please describe

If the organisation does have an appraisal system in place:

What is this called? – PDP/appraisal etc

Could you provide me with a brief overview of how it works? For example -
  - who conducts these (role, status, training)?
  - are appraisals of pharmacists conducted by other pharmacists? Should they be?
  - what about the appraisal of pharmacy technicians? are these conducted by other pharmacy technicians? Or another pharmacy professional?
  - how are they conducted/ what is the process?
- how often are they conducted?
- what is included? – what is the main focus (research? technical? Career development? Business outcomes?)
- is there a probation period for new staff?

Is it generalistic - the same appraisal system for all employees in your organisation?
E.g. temp staff, those on fixed term contracts?
How is the performance of these other staff measured?
Does it change over time?

Do you find the current appraisal system beneficial? In what ways?
If not, why not?
Do you think it could be improved? In what ways?

How useful do you find your appraisal system for assessing performance and identifying underperformance in pharmacists/pharmacy technicians?

In conducting appraisals or being involved in the appraisal system, what kinds of issues related to the performance and revalidation of pharmacists/ pharmacy technicians have you come across?

How relevant or useful do you think your appraisal system currently is for the assessment of fitness-to-practise and therefore in the revalidation of pharmacists and pharmacy technicians?
Do you think it could be adapted for that purpose?

Do you have any other systems in place which measure the performance of pharmacists/pharmacy technicians and might be incorporated into the revalidation process?
- please describe

For all interviewees:
What do you think revalidation is? E.g. “positive affirmation of one’s fitness to practise”

For pharmacists working in industry, who do you think should be overseeing the revalidation process?

What do you think revalidation should involve (for pharmacists working in industry)? Should appraisals be a part of that process?

What other sources of information do you think should be used? (e.g. 360 feedback, peer review, customer surveys, CPD etc).

What potential problems do you think could arise with any of these systems in collating information for revalidation purposes?

From your experiences do you think there is a particular group in your pharmacy sector that could potentially be problematic for revalidation purposes? (e.g. people working abroad?)

Do you have any other thoughts or comments on revalidation for pharmacists or pharmacy technicians working industry?
Appendix 3: Interview topic guides – schools of pharmacy

Can you give me a brief description of your role?

Does your organisation currently have an appraisal system which is used for pharmacists working in your department?
What do you call this (for example personal/ performance development review, performance monitoring)?

If the organisation does not have an appraisal system in place:

Do you think your organisation should have an appraisal system in place?
Who should conduct these? (internal or external; pharmacist or academic)
How should it be conducted?
Do you think it would be possible to incorporate issues relevant to revalidation in pharmacy into a system of appraisal?

Do you have any other systems in place which measure the performance of pharmacists and might be incorporated into the revalidation process?
- please describe

If the organisation does have an appraisal system in place:

What is this called? – PDP/ appraisal etc.

Could you provide an overview of how it works? For example -
- who conducts these (role, status, training)?
- are appraisals of pharmacists conducted by other pharmacists? Should they be?
- how are they conducted/ what is the process?
- how often are they conducted?
- what is included? – what is the main focus (academic, i.e. teaching and research?)
How is this 'assessed' – any other evidence? (e.g. student questionnaires/peer feedback for teaching/research
- is there a probation period for new staff?
Is it the same appraisal system for all employees in your department/organisation?
- E.g. pharmacist research staff, those on fixed term contracts?

What about pharmacists doing their PhD / post-graduate students? Do they have an appraisal system? Does it differ from that used for staff? Do all teaching staff retain practice time?

Do you find the current appraisal system beneficial? In what ways?
If not, why not?
Do you think it could be improved? In what ways?

How useful do you find your appraisal system for assessing performance and identifying underperformance?

In conducting appraisals or being involved in the appraisal system, what kinds of issues related to the performance and revalidation of pharmacists have you come across?

How relevant or useful do you think your appraisal system currently is for the assessment of fitness to practise and therefore in the revalidation of pharmacists (and pharmacy technicians)?
Do you think it could be adapted for that purpose? How?

Do you have any other systems in place which measure the performance of pharmacists and might be incorporated into the revalidation process?
- please describe

For all interviewees:
What do you think revalidation is? E.g. “positive affirmation of one’s fitness to practise”

For pharmacists working in academia, who do you think should be overseeing the revalidation process?
What do you think revalidation should involve (for pharmacists working in academia)? Should appraisals be a part of that process?

What other sources of information do you think should be used? (e.g. 360 feedback, peer review, student surveys, CPD etc).

What potential problems do you think could arise with any of these systems in collating information for revalidation purposes?

From your experiences do you think there is a particular group in your pharmacy sector that could potentially be problematic for revalidation purposes? (e.g. portfolio workers)

Do you have any other thoughts or comments on revalidation for pharmacists working in schools of pharmacy?

[Would it be possible to have a copy of the appraisal documentation?]
Appendix 4: Survey of Primary Care Organisations

PART II: APPRAISAL SYSTEMS FOR PRIMARY CARE PHARMACISTS & PTs

Does your PCO currently have an appraisal system in place for primary care pharmacists and/or pharmacy technicians (PTs)?

Yes, but only for pharmacists ❑
Yes, for pharmacists & PTs ❑
No, neither for pharmacists or PTs ❑ → if No - thank you for completing the questionnaire

If yes, who conducts these appraisals?

Line Manager ❑
Clinical governance lead ❑
Other (please describe) ❑ …………………………………

How often are appraisals conducted?

About every 12 months ❑
In response to an incident or complaint ❑
Other (please describe) ❑ …………………………………

What is contained / discussed in these appraisals? Please tick all that apply

Review of progress on personal development plan since last appraisal ❑
Review of CPD log/record ❑
Performance ❑
Identification of learning & development needs ❑
Agreement on personal development plan ❑
Other (please describe) ……………………………………………………………………………

On a scale of 1 to 5 (1= not at all adaptable, 5= very adaptable) do you think the current appraisal system could be adapted for the purpose of revalidation (i.e. for the positive affirmation of a pharmacist’s or PT’s fitness to practise)?
<table>
<thead>
<tr>
<th>Not at all adaptable</th>
<th>Very adaptable</th>
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**How would you feel about incorporating additional questions into appraisals for the purpose of revalidation?**

- No concerns about incorporating additional questions  
- Minor concerns about incorporating additional questions  
- Moderate concerns about incorporating additional questions  
- Major concerns about incorporating additional questions

**Do you have any comments you would like to add regarding the use of appraisal systems for the purpose of revalidation?**
Appendix 5: Survey of NHS acute hospitals / hospital trusts

PART II: APPRAISAL SYSTEMS FOR HOSPITAL PHARMACISTS & HOSPITAL PHARMACY TECHNICIANS (PTs)?

Does your NHS hospital (Trust) currently have an appraisal system in place for pharmacists and/or pharmacy technicians (PTs)?

Yes, but only for pharmacists
Yes, for pharmacists & PTs
No, neither for pharmacists or PTs

If yes - thank you for completing the questionnaire

If yes, who conducts these appraisals?

Line Manager
Clinical governance lead
Other (please describe)

How often are appraisals conducted?

About every 6 months
About every 12 months
In response to an incident or complaint
Other (please describe)

What is contained / discussed in these appraisals? Please tick all that apply

Review of progress on personal development plan since last appraisal
Review of CPD log/record
Knowledge Skills Framework
Performance
Identification of learning & development needs
Agreement on personal development plan
Other (please describe)
On a scale of 1 to 5 (1= not at all adaptable, 5= very adaptable) do you think the current appraisal system could be adapted for the purpose of revalidation (i.e. for the positive affirmation of a pharmacist’s or PT’s fitness to practise)?

Not at all adaptable

1 2 3 4 5

Very adaptable

How would you feel about incorporating additional questions into appraisals for the purpose of revalidation?

- No concerns about incorporating additional questions
- Minor concerns about incorporating additional questions
- Moderate concerns about incorporating additional questions
- Major concerns about incorporating additional questions

Do you have any comments you would like to add regarding the use of appraisal systems for the purpose of revalidation?
Appendix 6: Inspectorate interview guide

Can you give me a brief description of your role?

Could you please describe the processes you go through when you conduct an inspection on the pharmacy premises?

What is the process for any premises that does not meet the standards?

How will your role change following the establishment of the GPhC and the implementation of the new Pharmacy Order? (e.g. stronger powers of enforcement)

Other than through routine inspections, do you collect any other information relating to the performance of pharmacists or pharmacy technicians? (e.g. through customer complaints)

What is the process for dealing with these?

To what extent does the role of the Inspectorate join up with that of PCTs’ contract monitoring processes? (e.g. sharing information)

What kinds of issues related to pharmacists’ performance, or the performance of pharmacy technicians, have you come across in your work (even if not through formal inspection process)?

What do you think revalidation is? (E.g. “positive affirmation of one’s fitness-to-practise”)

Do you think that your inspection system, or any elements within it, currently lends itself to use for revalidation purposes? If so, which aspects? If not, why not?

Do you think that your role could possibly be extended to incorporate gathering information about individual pharmacists or pharmacy technicians for revalidation purposes? (if resources were made available to do this, would it be possible?)
If this is done what impact do you think this may have on your role? And the role of the inspectorate?

What potential problems do you see with carrying out such a process, i.e. using inspection visits (or something similar) for the purpose of revalidation?

Do you think there are certain groups within the profession that the inspectorate would be in a good position to take responsibility for? E.g. Locums? Independent owners? etc

If not the inspectorate, who do you think should be responsible for overseeing and conducting the revalidation process for pharmacists and pharmacy technicians?

How would you like to see such a system implemented and what would you envisage as a suitable sources of information for revalidation purposes (e.g. appraisals, 360 feedback, peer review, customer feedback, CPD etc). (could any info from the inspectorate feed into this?)

From your experiences do you think there is any particular group in the community or hospital pharmacy sector that could potentially be problematic for revalidation purposes? Any particular groups you think should be targeted?

Do you have any other thoughts or comments on revalidation for pharmacists and pharmacy technicians? (and the role of the inspectorate?)

Would it be possible to have a copy of the inspection documentation used?}
Appendix 7: PCT Monitoring interview guide

Can you give me a brief description of your role?

Could you please describe the processes you go through for a contract monitoring assessment?

What is the process for any pharmacy contractor not meeting the terms of the contract?

Other than through routine contract monitoring, do you collect any other information relating to the performance of pharmacists or pharmacy technicians? (e.g. customer complaints, patient surveys)

What is the process for dealing with these?

To what extent does the role of PCTs in pharmacy contract monitoring join up with that of the Inspectorate? (e.g. sharing information)

What kinds of issues related to pharmacists’ performance, or the performance of pharmacy technicians, have you come across in your work (even if not through formal contract monitoring process)?

What do you think revalidation is? (E.g. “positive affirmation of one’s fitness-to-practise”)

Do you think that your PCT’s contract monitoring system, or any elements within it, currently lends itself to use for revalidation purposes? If so, which aspects? If not, why not?

Do you think that your role could possibly be extended to incorporate gathering information about individual pharmacists or pharmacy technicians for revalidation purposes? (if resources were made available to do this, would it be possible?)
If this was done, what impact do you think it might have on your role?

What potential problems do you see with carrying out such a process, i.e. using contract monitoring (or something similar) for the purpose of revalidation?

Do you think there are certain groups within the profession that PCTs as commissioners would be in a good position to take responsibility for? E.g. Locums? Independent owners? etc

If not the PCT, who do you think should be responsible for overseeing and conducting the revalidation process for community pharmacists and pharmacy technicians?

How would you like to see such a system implemented and what would you envisage as a suitable sources of information for revalidation purposes (e.g. appraisals, 360 feedback, peer review, customer feedback, CPD etc).

What potential problems do you think could arise with any of these systems to collate information for revalidation purposes?

From your experiences do you think there is any particular group in the community pharmacy sector that could potentially be problematic for revalidation purposes? Any particular groups you think should be targeted?

Do you have any other thoughts or comments on revalidation for pharmacists and pharmacy technicians? (and the role of the PCT?)

[Would it be possible to have a copy of any documentation used in relation to contract monitoring?]
8 References


