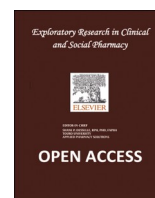


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A qualitative exploration of how pharmacy professionals in primary care utilise planned protected development time

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ABSTRACT

Background: With patients developing more complex healthcare and medicine needs, it is imperative pharmacy professionals enhance their knowledge and skills to enable an advanced level of pharmaceutical practice, improving service provision and supporting patient care. The UK Royal Pharmaceutical Society (RPS) is urging employers to incorporate protected time within the working week to facilitate this development. Currently protected development time (PDT) is not well established within the pharmacy profession and there is little qualitative data available about the utility of this.

Objective: To explore how pharmacy professionals in primary care currently utilise planned protected 'development time' and their perception of this.

Methods: One-to-one semi-structured interviews were conducted between February and March 2023 via Microsoft Teams® with pharmacists, pharmacy technicians (PTs) and pharmacy support workers (PSWs), working in a large Health board area in Scotland who had established PDT since August 2021. Interview recordings were transcribed verbatim and analysed using an inductive thematic framework approach.

Results: Interviews were conducted with 13 participants (12 female); 6 pharmacists, 5 PTs and 2 PSWs. Five core themes were derived from the data: logistics, competing priorities, methods for development, inequalities and benefits. Participants utility of PDT was variable, most focused on self-development to improve clinical knowledge however, supporting the development of others often taking precedence. Disparities in utility and inequity of protection from service delivery were highlighted. All participants benefited from PDT reporting a self-assessed improvement in confidence and competence.

Conclusion: The experience of participants who had PDT was typically perceived as positive including supporting development and improving wellbeing however, it fostered inequalities which needs addressing. Educational input is required to provide direction for development across all four pillars of professional practice; clinical practice, leadership, education and research, promoting advanced practice. Further research is required to assess the impact of PDT on health outcomes of the local population.

1. Introduction

The United Nations 2030 Agenda for Sustainable Development outlines a model for improving progress in global health.¹ As a response, the International Pharmaceutical Federation introduced developmental goals recognising the need to transform the pharmacy profession globally by enhancing pharmaceutical practice and education, empowering the advancement of the pharmaceutical workforce.² These goals define integration of professional development as essential to attaining this advanced level of practice.

Pharmacists are increasingly being asked to develop new services, and learn new skill sets to facilitate these, both clinically and non-clinically. There is a growing requirement for the workforce to integrate clinical practice, leadership, educational, and research skills (i.e. 'four pillars') across all roles and levels, to drive a greater skill mix which is both sustainable and meets the needs of the population; depicting the worth of the profession in their ability to make valued contributions to managing patient care.³⁻⁵ Four-pillar advanced practice competency frameworks are becoming more common place for pharmacy professionals and have proven to facilitate improved performance across a

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wider range of competencies.^{6,7} Many countries and regions are developing professional competency frameworks and accreditation systems.⁷

Recognising the continuously evolving healthcare needs of the population and the increased burden new complexities place on pharmacy professionals, pharmacy globally is moving towards a professional career pathway underpinned by continuing professional development and 'lifelong learning'. Annual continuing professional development (CPD) is a mandatory requirement of pharmacists in many different countries and healthcare systems.⁸ There is however significant variability in the implementation of CPD in each country.^{9,10} A lack of protected time is a known barrier to CPD in pharmacy across the globe.^{10–12} Different countries, healthcare systems, and employers are now trialling protecting development time for pharmacy professionals within their employment. Examples in the USA,¹³ Australia,¹⁴ Kuwait,¹⁵ and France.¹⁶ Different arrangements for this exist including structured programmes, ad-hoc study leave requests, and/or periodic self-directed protected time slots.^{13–16}

Within the UK, the pharmacy workforce training has historically adopted protected development time (PDT) within working hours predominantly within the first 2 years post-registration only,⁴ although PDT is well established in other healthcare professions (HCPs).¹⁷ The findings from a UK survey study highlighted that General practitioners (GPs) and general practice nurses were considerably more likely to have PDT than their pharmacy colleagues.¹⁸ However, the utility of CPD by pharmacists and pharmacy technicians (PTs) in the UK to develop clinical capabilities to meet requirements of revalidation outlined by the Pharmacy Regulator, the General Pharmaceutical Council, is well documented.^{19,20} It is perceived as lifelong learning practice that, unlike PDT, is well integrated into the profession. Recognition that many pharmacy professionals are unable to engage in PDT and the limited focus on leadership, educational and research capabilities^{4,6} has urged the professional body, the Royal Pharmaceutical Society, to lobby employers and government to provide PDT within working hours to facilitate this development.²¹

In NHS Greater Glasgow and Clyde (NHSGG&C), one of the largest Health Board areas in Scotland, pharmacy services published the strategic framework to remobilise the service through the pandemic and beyond.²² A strategic priority was a 'renewed focus on developing advanced skills across the pharmacy workforce'. Local guidance within primary care²³ published in 2021 to support team members work to the 'top of their license', proposed staff should have 10% of their working week protected to support professional development of self, service or others.

With the expectation of pharmacy professionals to work at the highest level of their practice across all four professional pillars, to continually improve service provision and with the adoption of competency frameworks, there is an increasing necessity for pharmacy professionals to enhance their knowledge and skills. Little is known about pharmacy professionals' use of PDT.

1.1. Aim

This study sets out to explore how pharmacy professionals in Primary Care currently utilise their planned PDT.

2. Objectives

To characterise the nature, content and time spent by pharmacy professionals as they undertake their learning in PDT and to explore how pharmacy professionals perceive the utility of this.

3. Methods

3.1. Design

To answer the aim a qualitative study design was utilised to capture

the narrative of participants to gain an in-depth understanding of how they utilised PDT and provide insight into their experiences, perception and opinions.

3.2. Setting

The study was conducted within West Dunbartonshire (WD) Health and Social Care Partnership (HSCP) in NHSGG&C,²⁴ covering an area of approximately 98 mile² and providing children's and adult's community health and social services to a population of 87,790.²⁵ The WD Primary Care Pharmacy team consists of 13 pharmacists, 11 PTs, 6 pharmacy support workers (PSWs) and 2 pre-registration pharmacy technicians. Pharmacists are Masters level qualified registered healthcare professionals who are focused on the safe and effective use of medicines. PTs are registered college level qualified healthcare professionals focused on the technical management and supply of medicines. PSWs are unregulated pharmacy staff involved in administrative and support functions. PDT has been established within the WD pharmacy team since August 2021.²³

3.3. Sampling

A purposive sampling strategy was used to identify participants across a range of pharmacy professions with a variety of experience with PDT. From literature a sample of between 8 and 16 participants was estimated to achieve saturation.^{26–29} Participant inclusion criteria included; a) Pharmacists, PTs or PSWs, and b) permanent or fixed-term employment within WD HSCP. Exclusion criteria; a) staff members on extended leave (e.g. sick or maternity leave), or b) those actively involved in the study (i.e. authors).

3.4. Participant recruitment

A participant information sheet was disseminated via internal email in January 2023 (FC) to 27 potential participants. A reminder email was sent (GC) 1 week later. Interested participants were invited to contact the lead researcher via email or telephone, a date for interview was then arranged and a participant consent form issued. These were returned by email prior to the interviews. The lead researcher was contacted by 17 potential participants agreeing to partake, all met the inclusion criteria and therefore were all selected for interview.

3.5. Data collection

A semi-structured interview schedule was developed (see Appendix A), broadly based around the four components of normalisation process theory.³⁰ The interview schedule was piloted on two pharmacists and then adapted. These pilot interviews were excluded from the study. Interviews took place between February and March 2023, via Microsoft Teams®. At the point of interview verbal consent was reconfirmed, participant demographic information was obtained, and participants were reminded of the purpose of the study (FC). All interviews lasted between 15 and 40 min and were video recorded then subsequently transcribed verbatim (FC and RP) utilising the transcripts produced by Microsoft Teams®. Transcripts were anonymised and then checked for accuracy (GC), they were not returned to participants for comment. All data relating to the study was stored in a secure password-protected location on an NHSGG&C network. These recordings were deleted immediately following validation of transcripts as per local data governance protocols.

3.6. Data analysis

Three coders were involved in data analysis, 2 female (FC and GC) and 1 male (PF), all of whom are pharmacists with 10–21 years experience working across primary care, community and hospital-based

pharmacy. An inductive thematic framework analysis approach was utilised following familiarisation of the initial data set of 10 transcripts, with a stopping criteria of 3.^{26,31} Key issues and recurrent concepts were annotated onto hard copies of the transcripts in an inductive manner to generate initial codes (FC). Four out of ten transcripts were also independently coded (GC & PF). All three coders then met face-to-face to agree preliminary codes and an initial thematic framework. Microsoft Excel® facilitated data management. Six further interview transcripts were coded (FC) applying the framework. Any themes which were outlying from the framework were then discussed at another face-to-face meeting between coders and the framework was refined as needed. Consensus agreement resolved any differences in interpretation of the data. A final framework was set after ten interviews. Further participant recruitment and data analysis continued, in blocks of three, until data saturation was attained, at which point recruitment ceased.

4. Results

Data saturation was reached after conducting 13 interviews, involving pharmacists (n = 6), PTs (n = 5) and PSWs (n = 2). Summarised characteristics are shown in Table 1.

Five themes were derived from data analysis depicting the utility, and perception of utility, of PDT which are outlined in Fig. 1: logistics, competing priorities, methods for development, inequalities and benefits. Illustrative quotes for each theme and sub-theme are presented in Table 2.

4.1. Theme 1- logistics

4.1.1. Sub theme 1.1 Understanding of concept

All participants were aware that PDT had been allocated into their working week to support their own development, that of their colleagues and the pharmacy service.

“my understanding is it’s to develop yourself and others within the team and give you the opportunity to advance your role and support others to do that as well.” (T2 Technician).

4.1.2. Planning of session

Most planned in advance how PDT would be utilised and structured their time.

Table 1
Participant demographics.

Gender, n	
Female	12
Male	1
Time qualified, years Median (IQR)	9 (6–11)
Time in current role, years and months Median (IQR)	2y (1y 4.5 m - 3y 6.5 m)
Industries with previous experience, n	
Community Pharmacy	11
Hospital pharmacy	3
Current training/qualification being undertaken, n	
Independent prescribing	3
Post-grad Masters	1
SQA work based assessor ^a	2
SVQ Pharmacy Services ^b	2
Enrolled within a framework*, n	
National Education for Scotland ³²	9
Royal Pharmaceutical Society ⁵⁵	2

IQR interquartile range (Q1-Q3) ^aScottish Qualification Authority awarded qualification for practitioners to equip them with requisite skills and knowledge to assess competence and vocational skills and knowledge in the workplace. ^bScottish Vocational Qualification in pharmacy services awarded by the SQA, internationally recognised qualification demonstrating competence in pharmacy related skills. *Defined curriculum utilised for training and development, underpinned by professional standards, describing expectations in terms of knowledge, skills and behaviours of pharmacy professionals.

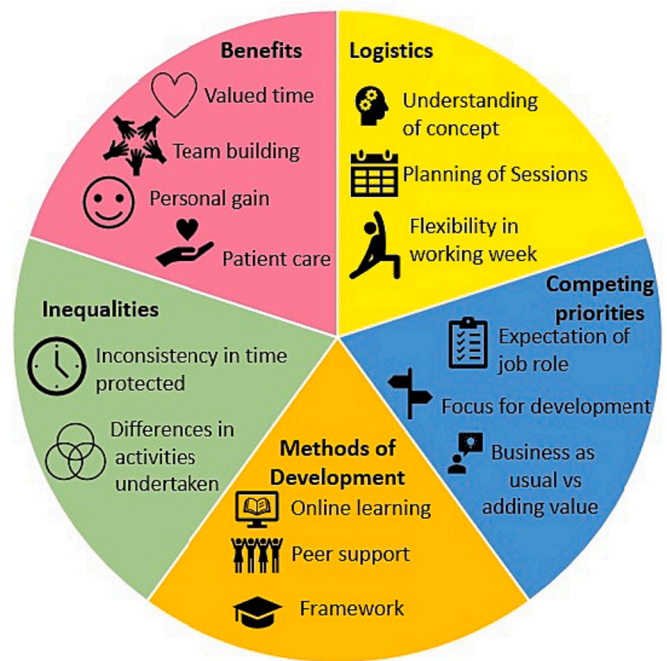


Fig. 1. Pictogram of 5 main themes and sub themes as identified from interviews.

“I would say there’s always something to be done. It’s very rare that I would be coming in not knowing what to do” (P4 Pharmacist).

Although, how participants structured their PDT often varied on a weekly to monthly basis, depending on changing priorities.

4.1.3. Flexibility in working week

All participants described using PDT flexibly, to facilitate undertaking development tasks without disruption to pharmacy service delivery.

“[PDT sessions] provide that kind of flexibility within quite a rigid working system, like I say to be able to kind of payback time for practices if needs be.” (P1 Pharmacist).

This flexibility afforded participants a relief from workload pressures. PDT enabled them to plan their working week providing ‘breathing space’ which relieved stress and reduced the risk of burn out.

“we really do need it [PDT] because otherwise it becomes this immense pressure trying to fit...commitments into our workload in practice, which is just really stressful” (P5 Pharmacist).

4.2. Theme 2- competing priorities

4.2.1. Expectation of job role

How participants chose to utilise PDT varied. All participants, in some capacity, described tasks indicative of their routine role, utilising it as a space to “catch up” on workload; managing emails and preparing for meetings.

“if there was anything of like, immediate concern or anything I’ve not been able to attend to in practice over the previous days because of workload restraints” (P1 Pharmacist).

All PTs described using PDT to complete “sign offs” to facilitate induction of new team members. Most felt that this facilitated development of both supervisor and trainees’ skills and knowledge rather than being a requirement of service provision.

“As a team we were trying to get the technicians to be signed off on outpatient letters. So obviously ideal opportunity for us would be to use [PDT] and that’s furthering our skillset” (T4 Technician).

Similarly, some pharmacists viewed assessing patients for antiviral medication during PDT, a service of consequence due to the COVID-19

Table 2
Illustrative quotes from interviews highlighting themes and sub-themes.

Theme	Sub-theme	Exemplar quotes
Logistics of PDT	Understanding of concept	“My understanding is that it’s to be sort of protective time for personal professional development as well as development opportunities for others in the team and also to build a facility, work above and beyond the standard level 1/ 2/ 3 [pharmacotherapy] practice.” (P1)
	Planning of sessions	“So I use the outlook calendar to plan my NCT [PDT] time in advance and so I would have that time blocked off and I would put whoever, if it was a shadowing session, I’d put whoever I’m shadowing in for that slot.” (P4)
	Flexibility in working week	“I suppose just knowing, I’ve got, I’ve got that kind of half a day, as I say to juggle, I’m not, it doesn’t stress me. Like if I’ve got something I need to do, I don’t get stressed out because I know I’ve got that time that time there to do it.” (T2)
Competing priorities	Expectation of job role	“I don’t know how all this would have fitted in before we had it and with workload pressures getting more and more and continually advancing our roles, I think it’s crucial that we maintain that [PDT] because I don’t know what we would do without it” (P6)
	Focus for development	“[use PDT to] pick up anything that I’ve not had time to do during the week and various things cause I do oversee the hub so I do have try to get round practice managers etcetera, with information or anything that needs sorted.” (T3)
	Business as usual vs adding value	“I have went on to learn pro and I’ve seen something that I think is going to benefit me, because we’re going to be doing this peer review thing. There was some interesting learn pros about doing a presentation, which I thought would be handy.” (S1)
Benefits	Business as usual vs adding value	“I need to take a wee bit more responsibility because, you know your [PDT] is meant to be for yourself and developing others. I think I’m, I don’t want to say overly keen or overly enthusiastic, in giving my time away to other people. I think maybe when I do get it, maybe the trick is I need to be a wee bit more selfish” (T1)
	Business as usual vs adding value	“...with newer members of the team that I line manage but then also might check in with them out with their kind of scheduled one to ones just to see how they’re getting on, particularly if they’re in a challenge in practice or if there’s a particular thing” (P5)
	Business as usual vs adding value	“But then also sitting on the prescribing group and thinking about, you know, budget things and cost efficiencies and the need to get GP practices on board with that, working collaboratively and doing acute to repeat things” (P5)
Benefits	Business as usual vs adding value	“I was developing a mental health guideline or best a, best practice guide, so not specifically a protocol or a guideline, but a document which is used to support the pharmacist and

Table 2 (continued)

Theme	Sub-theme	Exemplar quotes
Methods of development	Online learning	technicians in the reviewing of antidepressants for purposes of reducing acute burden on practices.” (P1) “I’ll use online resources for example, like Turas [department web based learning platform], learn pro, other external training sites to be able to go and have a look for courses.” (P1 Pharmacist)
	Peer support	“I would use Turas [department web based learning platform] and learn pro, going in and see what modules I can complete and to kind of keep myself up to date” (T5) “I have been supervised doing medication reviews, been supervised taking drug histories or telephone consultations and that kind of thing, and also peer audits.” (P4)
	Framework	“...for my [PDT], I’ve maybe not done the actual task I’m working on during that, but I’m using that to like fill it out, link it to frameworks, and expand on it and write reflections on that.” (T1) “I’m not really up to speed with that the now [framework]. I don’t even know what is classes as a supervised learning event.” (S1)
Inequalities	Differences in activities undertaken	“So, the other pharmacists within the team and then kind of otherwise it would be predominantly case based discussions with, senior clinicians, within practices that I work in.” (P1)
	Differences in activities undertaken	“I’ve not had anyone come ask me to come and watch them in their, in my [PDT] which again is something that I should, I could use my [PDT] for to do an SLE for someone else.” (P5) “At this current time, no, I’ve not had it [PDT] for a long time because of sickness cover in the hub so my time is actually pulled to basically cover the hub” (T3)
	Differences in activities undertaken	“So that was quite difficult because you may have this other work planned and then you kind of have to put that on hold last minute if Paxlovid [antiviral service] comes in and it’s just part of the role.” (P4) “I wouldn’t say I do a massive amount of supporting other members of the team during that time [PDT], it’s more my level 1 [pharmacotherapy service]” (P4)
Benefits	Valued time	“I’ve had a few conversations with colleagues, and they are using it to do practice work. And I have overly emphasized that it’s not for that. And then these colleagues then say how they’re very stressed because they can’t manage to get to XYZ meeting. So I think yeah, clarity and reinforcements needed over what [PDT] is for.” (P5) “I think that we are very lucky that we are allocated any [PDT]. I know we’ve been on and off different groups like whether it’s support worker groups or my college group or whatever, a lot of HSCPs don’t get it, so I do appreciate it

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Table 2 (continued)

Theme	Sub-theme	Exemplar quotes
		when I do get it.” (T1)
		“I’m really appreciative for it [PDT] and grateful, I don’t know if other teams get it, so I think it’s it’s a great thing that we get included in this area.” (T5)
		“I just think it’s really good and we need to protect it and we also need to make sure that we all use it in the way it’s meant to be used.” (P5)
	Team building	“it means I can go to the office [during PDT] which means that I can build relationships with other people in the team, so other pharmacists and support workers, technicians, because otherwise I feel I wouldn’t really have got to know them as well.” (P3)
		“...if it was having to be done [development] out with work time at different hours or if we didn’t have protected [PDT] it would make it a lot harder to link up with people to have these kind of conversations. So, I think that yeah, fantastic in that respect.” (P1)
	Personal gain	“So I think having that wee allotted time to actually focus on something it does, it really really helps.” (S2)
		“So yeah, it has definitely improved my confidence with a lot of things, cause being a mentor, I hadn’t done that before.” (T3)
		“And if I didn’t have that, I know myself that I wouldn’t be as motivated, I don’t think when it came, if it was to be out with working hours, it would be done, but it would feel harder to get it slotted in with how busy life is in general” (P1)
		“So in order for me to facilitate my role in advanced practice, I’ve gained the skills of polypharmacy and the confidence to then actually go do these reviews in a clinic myself through my time in [PDT].” (P4)
	Patient care	“I like to do a good job. I like to be a good pharmacist and be professional and deliver good quality care to patients and I can’t do that if I don’t keep up to date with, you know, with new developments and new drugs and new management of conditions” (P5)
		“I think it’s great [PDT]. I don’t know what we did without it. It’s obviously benefitting us I’d say from personal experience, allowing us to develop and the practices and then ultimately that will benefit the users of the service as well, if we are advancing our roles” (P6)

pandemic, as self-development rather than an expectation of their role.

4.2.2. Focus for development

Most participants in role less than 2 years were undertaking further training which compelled them to prioritise their own learning. Pharmacists and PT’s prioritised improving clinical knowledge in self-identified areas and described undertaking activities in a “tick box” manner to satisfy requirements of training or frameworks. PSWs focussed on enhancing soft skills to facilitate their job role such as

communication and listening skills. Development of leadership skills did not feature heavily in any participants narrative.

“finding my way in primary care, you know, taking on the breadth of learning from that and then obviously developing myself with my formal qualifications and my frameworks, I think they’re probably higher priorities” (P3 Pharmacist).

Focusing on development of others was notable for participants in senior roles and tended to take precedence over personal development. Many prioritised others development within PDT because of an obligation to support colleagues, feeling “selfish” focusing on themselves.

“Development of others absolutely, development of the service absolutely, development of self? Not recently”(P5 Pharmacist).

Participants supported others in a professional capacity through mentorship and supervision noting a pastoral level of support, explaining they use PDT to “check in” on new team members and offer their “help” and advice to colleagues.

4.2.3. Business as usual vs adding value

Most participants, except PSW’s, reported engaging in some form of service development to varying degrees during PDT however, the activity described indicated a lack of awareness of a true understanding of the concept. Expectations of participants role, training of colleagues, attendance at HSCP or health board level meetings, quality improvement work or reviewing prescribing practice, were erroneously portrayed as service development.

“Getting them trained up to switch people safely, appropriately, from standard repeats or even acutes to serial prescribing. And that’s actually really helping develop the service as well, I think” (T1 Technician).

Of all participants only 2 pharmacist expressed utilising PDT to seek out future opportunities for interventions to develop the pharmacy service. The development of protocols to facilitate medication reviews in different areas was described by pharmacists and PTs however, an apparent outcome was reinforcement of existing service provision opposed to delivery of a new service.

4.3. Theme 3 - methods for development

4.3.1. Online learning

The choice to use online resources to facilitate self-directed learning featured heavily in the narrative of all participants, including NHS e-resources and/or webinars. Online courses were preferred due to ease of access, the structured learning environment and to comply with statutory and mandatory training. Some participants thought that attendance at local team-coordinated webinars was almost compulsory and made use of PDT to attend these.

“I did the diabetic training session...so we had to do that.” (T2 Technician).

Participants also opted for these when they had no plan for PDT, as a means to an end.

“I can just go into Turas [department web based learning platform] and have a look and see, even if I’ve not got anything planned in for [PDT]”(T4 Technician).

4.3.2. Peer support

General peer discussions about clinical cases and shared learning events were often conducted during PDT. PT’s and PSW’s tended to utilise knowledge and skills possessed by each other and did not recount seeking support out with the pharmacy team.

“I’ve really just collaborated with the people I work with every day. I’ve not really done anything with another member out with the immediate [pharmacy] team.” (T2 Technician).

Pharmacists were more likely to utilise the wider multidisciplinary team (MDT) and described spending PDT shadowing peers and other clinicians practice to meet training requirements.

4.3.3. Framework

All participants except PSW's were enrolled in a 'professional framework'. However, some partook in activities to meet expectations outlined in the curriculum as a matter of necessity, rather than to facilitate development. Administrative tasks such as uploading evidence online, writing reflections and completing supervised learning events (SLE's), were undertaken most. SLE's are tools utilised by learners to gain formal feedback from an assessor or supervisor on specific skills via clinical discussions or direct observation of practice. This feedback encourages development through reflection of good practice and areas for improvement with an aim to improve confidence and competence.

"Yeah, generally doing write ups....and making sure that I'm covering the framework and covering the outcomes that that they expect us to do." (P2 Pharmacist).

Employing PDT to facilitate clinical interactions to complete SLE's was only described by 2 pharmacists. Participants expressed that SLE's were not their preferred method for development and therefore not prioritised. PT's and PSW's conveyed a lack of understanding of SLE's and the different assessment tools available, they perceived these as being steered towards pharmacists' development which was a barrier to their utilisation.

"I think it's mostly just because of the terminology and the words that are used. It's more like angled towards pharmacists" (T4 Technician).

Pharmacists mostly engaged in case based discussions in collaboration with peers or clinicians within their GP practice team. Only one pharmacist described collaborating with a specialist clinician out-with their immediate MDT. Pharmacists had generally undertaken more SLE's as a 'learner' compared to PT's, no participants mentioned utilising PDT to act as an 'observer'.

4.4. Theme 4 - inequalities

4.4.1. Inconsistency in time protected

A clear disparity between PT's/PSW's PDT being withdrawn compared to pharmacists was reported. Pharmacists PDT was more likely to be protected, with exception of supporting the COVID-19 antiviral service. All PT's/PSW's acknowledged that the need for adequate staffing resource to preserve the technician-led 'hub' service was prioritised however, described feelings of dissatisfaction having PDT regularly withdrawn.

"it can be quite frustrating when you're consistently losing it[PDT]. And because it's very hard to plan, it's very hard to find time from somewhere else." (T1 Technician).

This sense of frustration from PT's continued when depicting disparities they also believed existed in the frequency of PDT being 'pulled' varying between PT's.

"I get frustrated because, it seems like, some people never lose theirs. There's no adjustments within the team to say, well, you've consistently had your [PDT] for the past six weeks, and this persons only managed to get it once" (T4 Technician).

Some pharmacists contested that participating in activities which don't directly relate to any aspects of development demonstrates that PDT is not wholly protected for pharmacists either.

"I do try to use for my own development but, it does get eaten up with other stuff. If there's meetings on then, then that's then[PDT]." (P5 Pharmacist).

4.4.2. Differences in activities

The volume and breadth of activities undertaken by participants was highly variable between professions and within each role. Participants with more tenure or seniority depicted extensive activity to develop themselves and others, whilst one pharmacist described mentoring colleagues, supporting students, acting as a designated prescribing practitioner and undertaking management duties during PDT, most other pharmacists accounts did not reflect this.

"I don't do mentorship myself, no" (P1 Pharmacist).

There was a sense of achievement displayed by some participants when recounting the utility of their PDT.

"I don't think you realise just how much you actually do until you sit down and you say all of this." (T2 Technician).

An awareness of disparity in activity levels was articulated in acknowledging that some peers focused only on self-development or only used PDT as means to relieve workload pressures. The viewpoint of some painted this inequality as potentially detrimental to team morale.

"if it's so obvious, why is it that there is so much of a disparity? I think if that's not picked up on it can cause resentment." (T4 Technician).

4.5. Theme 5 - benefits

4.5.1. Valued time

All participants responded positively to PDT, conceding it was invaluable to facilitate development and should be utilised effectively given that as a profession, pharmacy is not often afforded this time.

"having chatted with pharmacists that are in other health board areas that don't have [PDT], the common theme that I hear is that everybody wants [PDT] to be able to support their work" (P1 Pharmacist).

A feeling of protectiveness over PDT was apparent in expressions of the need to make certain PDT was used as intended to illustrate continued benefits to development of self, others and the service.

4.5.2. Team building

Participants illustrated that PDT enabled the pharmacy team to work collaboratively, and promote peer support and stronger working relationships which otherwise would not be possible. Participants in role less than 2 years described PDT as fundamental in orchestrating effective transition into the team.

"[PDT] allows us to link up a little bit better between kind of working in our individual silos that we tend to do within pharmacy" (P1 Pharmacist).

Participants depicted PDT improving visibility of pharmacists and PT's both within the pharmacy and GP practice teams. Having the time afforded to meet with individual practice teams as well as external links empowered participants to better enhance existing working relationships.

4.5.3. Personal gain

Participants described how PDT made them more motivated to enhance their own skills and knowledge. It was depicted to have created a better work-life balance for participants and many believed PDT made them more competent and confident within their role, bestowing participants with more job satisfaction.

"I wouldn't do as good a job in my clinical role...I definitely wouldn't be as supportive because I literally wouldn't have the time to" (P5 Pharmacist).

PDT was described as instrumental in enabling some participants to complete further training or qualifications and advancing their clinical practice.

"I recently have just qualified as an SQA work based assessor, so I really, really appreciated having that [PDT]. I don't know how I would get through that if I didn't have my [PDT] at work" (T4 Technician).

4.5.4. Patient care

Many participants explained that their motivation to undertake developmental activities during PDT was to ensure the delivery of safe and effective patient care. As a result of PDT participants deemed they were more knowledgeable, able to communicate more effectively and had improved their provision of care thereby, improving outcomes for patients.

"motivation to better myself and better my knowledge and therefore give patients a better outcome at the end of the day as well." (P4 Pharmacist).

4.6. Strengths and limitations

This study is the first to contribute to the understanding of how

pharmacy professionals utilise PDT and their perception of this. It has been reported according to the consolidated criteria for reporting qualitative research (COREQ) guidelines.³³ The methods used gained actual insights, using an established philosophical model for implementing complex interventions, from participants who have PDT established for over 1 year. With the desire to implement PDT for pharmacy professionals currently coming to the forefront,^{21–23,34} the timing of this study is optimal to reinforce the need for this to become common practice.

The strengths are that this is one of very few investigations into this topic however a major limitation is that the interviewer (FC) was not independent and closely involved in a professional capacity with all participants which may have introduced some response bias. However, this familiarity may present potential benefit in facilitating improved rapport between interviewer and respondent although, the effects of this on data quality remains undetermined.^{35–39} As the participant sample was small ($n = 13$) and disproportionately female compared to the wider workforce, these findings may not be generalisable.

5. Discussion

An understanding of why PDT was implemented was apparent however, this did not translate into participants focus for development. Conflicting interests were evident. Use of online resources for self-development was preferred, predominantly to improve clinical knowledge. Participants displayed a discomfort implementing SLEs, accounts of supervised practice with other clinicians was modest, resultant from misconstrued views of SLE's.

Disparities in the utility and consistency of PDT was highlighted, raising concerns about the fairness of allocation however, it was clear that all participants valued PDT. PDT increased capacity for development, improved wellbeing and invoked greater job satisfaction. Self-reported improvements in confidence and competence were advocated.

5.1. Context

There is plentiful research exploring pharmacy professionals involvement in CPD activity^{17,18,40,41} providing insight into personal development and it's use to evidence their competency to practice in their current role.^{9–12,18–20} However, literature describing utilisation of PDT in the working week to develop pharmaceutical services or support development of others in order to evolve the profession and improve future practice to support the needs of the population is scant. This and the recent RPS publication calling for established PDT,³⁴ indicates poor integration within the profession. A lack of service development was depicted in this study, many participants interpreted their activity as service development focused on quality improvement and audit. There was little evidence of innovation or involvement in expansion of services out-with their own pharmacy team, contributing only to maintenance of current service provision. This account is reflective of similar services in other geographical, clinical and professional areas; GPs report undertaking audits during PDT¹⁸ and focusing on improving prescribing quality to reduce adverse outcomes for patients, rather than evolving services.⁴²

The implementation of CPD varies across the globe nonetheless, the requirement for pharmacy professionals to undertake CPD to evidence up to date skills and knowledge will always be essential to comply with regulators standards and demonstrate current professional competency.^{8–12} Contrastingly, the implementation of protected time within pharmacy professionals employment provides opportunity for planned development of the pharmaceutical service and empowerment of individuals to evolve their future practice in a structured manner, thereby creating a future workforce which is responsive to the changing needs of the population.

Unlike the findings of this study, competing priorities between self-development and development of others is not a predicament endured

by other professions, a preference for self-development focusing on improving clinical knowledge is evident.^{17,43–45} Evaluations of established PDT in primary healthcare teams illustrated HCPs applying knowledge gained during PDT in practice^{44,45} however, improving assessment skills and increasing awareness of local services for patient referrals were also an important element of self-development.

Many participants employed online resources to facilitate their learning, this appears to be more prevalent for pharmacy professionals, particularly PTs.¹⁸ Although some online platforms, such as Turas Learn®(the approved NHS web-based learning platform), direct users to complete an assessment of learning, other online resources such as generic webinars do not offer reinforcement of learning nor afford an evaluation of benefit.⁴⁵ Participants desire to learn via peer support is more widely reported.^{17,18,42,46} Interprofessional learning was rarely adopted to meet personal developmental needs, which is consistent with other literature, with GPs and nurses depicting learning outside of their profession as unvaluable.^{17,18,43,47} Despite the utility of peer support being a dominant narrative, an absence of preceptorship was demonstrated, comparably with the adoption of the preceptee role for self-development. This is substantiated by the literature demonstrating the concept as a less favoured method for self-development,¹⁸ although commonly adopted to support early years learning.^{48–51}

Improved working relationships was a prominent benefit described by participants. Despite the disinclination for interprofessional learning, in terms of improving team working, the genuine networking and team building opportunities afforded by PDT is widely reported.^{17,43,45,47,52} This advantage alone was deemed important enough by HCPs to continue implementing PDT^{17,43,53} particularly in those professions who work in isolation resonating with the opinion of participants in this study.

Sacrificing PDT to ensure adequate service provision is not unique to pharmacy professionals, other HCPs suggest PDT is not sufficiently protected from service delivery.^{43,52} The inconsistencies highlighted in this study appear to translate across multiple primary care clinicians, in comparison with their colleagues pharmacists and PTs are significantly less likely to have access to PDT.¹⁸ There is no evidence available for PSWs with any regard to PDT. However, PDT is considered as a valued investment of time by those afforded the opportunity to undertake it,⁴⁷ it's perceived benefit of increasing capacity for self-development for HCPs is appreciated.^{17,52} These sentiments are aligned with the participants of this study, evident in the expression of gratitude throughout the interviews.

5.2. Next steps

PDT had a positive personal impact on participants with regards to supporting their development and improving wellbeing however, the need to address inequalities in its uptake and implementation was highlighted. To reduce disparities in utility of PDT and inequity of protection from service delivery, an assessment of allocation is required which ensures compliance with legislation⁵⁴ and NHSGG&C recommendations²³ for PDT making equity more attainable.

Participants were afforded autonomy to prioritise learning needs, their focus demonstrated minimal involvement in service evolution and mainly centred around improving knowledge and supporting others, therefore further intervention around the effective use of PDT is required. An understanding into why participants acknowledged use of preceptorship and SLEs to support self-development but ultimately favoured online learning is also necessary. Educational input demonstrating incorporation of SLEs in PDT, would provide direction to support development across all four-pillars of professional practice.

6. Conclusion

PDT for pharmacy professionals in the UK is in its infancy and this study gives an important insight into the early experiences of pharmacy

professionals. Participants responses determined 5 interplaying elements effecting the implementation of PDT; logistics, competing priorities, methods for development, inequalities and benefits. Further research is required to assess these consequences in order to maximise the impact of PDT on personal development and on health outcomes of the local population.

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CRedit authorship contribution statement

Fiona Cairns: Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. **Robyn Patrick:** Project administration, Validation, Writing – review & editing. **Gillian Calderhead:** Conceptualization, Formal analysis, Supervision, Writing – review & editing, Validation. **Paul Forsyth:** Formal analysis, Methodology, Supervision, Writing – review & editing. **Gazala Akram:** Conceptualization, Supervision.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

No data are publicly available.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.rcsop.2024.100417>.

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