The Pharmacists' Defence Association's Response to the APTUK / PCPA National Competency Framework for Primary Care Pharmacy Technicians consultation.

About the Pharmacists' Defence Association

The Pharmacists' Defence Association (PDA) is a not-for profit defence association and trade union for pharmacists.

It is the only organisation that exclusively looks after the interests of employee and locum pharmacists across all sectors of pharmacy, currently with a membership of more than 32,000, the PDA is the largest representative membership body for pharmacists in the UK and this membership continues to grow.

Delivering more than 5,000 episodes of support provided to members who have found themselves in a critical incident situation in the last year alone, provides the PDA with a rich vein of up to date experiences which have informed policies and future strategy.

The practical experience gained in supporting member issues from the coal face is further enhanced by regular member surveys and focus group interactions. The proposals put in this document are largely built upon this experience and the lessons that emerge.

The primary aims of the PDA are to:

- Support pharmacists in their legal, practice and employment needs
- Represent the individual or collective concerns of pharmacists in the most appropriate manner
- Proactively seek to influence the professional, practice and employment agenda to support members
- Lead and support initiatives designed to improve the knowledge and skills of pharmacists in managing risk and safe practices, so improving patient care
- Work with like-minded organisations to further improve the membership benefits to individual pharmacists
- Arrange insurance cover for individual pharmacists to safeguard and defend their reputation.

Introduction:

The PDA supports and encourages the development of pharmacy technician roles just as we support the development of pharmacist roles in supporting GPs in primary care.

As a solely pharmacist organisation, the PDA does not have pharmacy technicians in its membership. However, it fully appreciates that pharmacy technicians are valued colleagues who work alongside its members every day; they are often the friends, family and the fellow employees working together as a team.

If that skill mix is to work, then it is important that pharmacy technicians have rewarding jobs with career development, job security, respect at work and fair reward, just as these things are important for pharmacists. But before those objectives we must always place the safety of patients and the effectiveness of their care as our priority.

Just as individual pharmacists work with technicians in the pharmacy, the PDA seeks a positive working relationship with organisations that represent technicians and this full response to the APTUK consultation is intended to assist the APTUK in the development of a suitable framework.

We hope that following the consultation exercise and review of the feedback received from all respondents the revised proposal can become something which would add value to patients and the pharmacy team and can be something that the PDA can support."

The safety and interests of patients, which should always be our first and foremost concern, are always best served when all NHS staff work symbiotically and within their training and competencies for the benefit of patients.

This NCF document, as proposed, has the potential to cause patient harm as it proposes professional roles for technicians whose training and experience has prepared them for a level 3 technical role.

We fully accept and support that if skill mix is to work effectively for patients, then it is important that technicians have rewarding structured career pathways

just as pharmacists would expect to do so. Pharmacists in GP surgeries share the workload in supporting GPs to look after patients.
Sadly, this NCF has focused on attempting to substitute the professional role the pharmacist discharges in primary care with a technician who does not have the underpinning clinical knowledge or skills to attempt the majority of the proposed criteria.

The NCF is a document that is overly ambitious and seeks to carve out a wide area of work for technicians without having due regard to many critical stepping stones that put patient safety at its core. In doing so it seems to be attempting to substitute the technician for the pharmacist.

Even the PCPA ***"A guide for GPs considering employing a practice pharmacist"*** which was published in conjunction with the Royal College of General Practitioners clearly notes ***"Entry Level (junior)"*** roles and ***"Advanced Level(senior)"*** roles. (1)

The NCF is not presented in a manner which clearly identifies roles nor does it recognise or acknowledge the complexity of some of the proposed competencies.

It is also notable that the Association is terming itself a "professional leadership body" when it really should only describe itself as a "leadership body" as a level 3 technician qualification cannot be meaningfully described as an entry route into an autonomous "profession".

Further, the APTUK has not demonstrated that it has reached that the requisite threshold in terms of inclusiveness, education and in other aspects to call itself a "leadership body" or a "professional leadership body".

This is noted within the 2016 study conducted by the University of East Anglia (2):

> ***The professional leadership body does not have sufficient members to truly say it is the voice of pharmacy technicians. They are predominantly led by hospital pharmacy technicians which means that there is a lack of understanding of other sectors which makes it difficult for them to take issues forward."***

It is notable that the then President of the APTUK was a named co-author for this report.

The Health and Care Professions Council (HCPC) criteria for any occupational group that wishes to be recognised as a healthcare profession is that at least 25% of the eligible occupation should be members of the 'professional' organisation. (3) The APTUK has not demonstrated that it has reached this barest minimum threshold.

The HCPC when considering registration for a professional group would look at the numbers admitted by any grandparenting clause that were applied for members of any new "profession". There are significant issues around the grandparenting rules that were applied when pharmacy technicians became subject to mandatory GPhC registration.

This grandparenting route, by which the majority of technicians 61% are still registered is of considerable concern. (4)

The GPhC Chairman, when asked at a national conference indicated that the GPhC had created a register of pharmacy technicians, but a large proportion had joined this register through a grandparenting arrangement and as a result, there were some very variable standards amongst those on the register. He explained that it was therefore not possible for the regulator to take a blanket view and to recommend to pharmacists what roles they should delegate to pharmacy technicians. A generic approach to the group was not possible.(5)

The NCF, as presented, is not helpful for the meaningful and structured development of the role of the pharmacy technician. By being overly ambitious it may have serious patient safety implications and over the longer term it may hinder the development of roles for technicians.

Our shared pharmacy wide ambition should be on providing better pharmaceutical care for patients. In order to fulfil this vision, it is vitally important that pharmacy technicians develop their skills in support roles for pharmacists, just as pharmacists have developed clinical skills and competencies (and are continually developing these) in supporting GPs.

Overarching Recommendation for the whole NCF :

- This NCF must be rewritten in entirety to reflect the support role that technicians can perform in supporting pharmacists to support GPs.
- The PDA and APTUK/ PCPA should work together to deliver a structured plan, building on the key skills of pharmacy technicians as key support staff for pharmacists within the pharmacy sector.
- The whole revised NCF to recognise at all stages the symbiotic working of the technician with the clinical pharmacist within the whole multidisciplinary team.

Section 1 – Introduction

The introduction is intended to be clear about who has been in the development of the competency framework and the drivers for the framework.

7.Do you have specific recommendations for improvements to the 'Introduction' section of the framework?

(●) Yes

( ) No

8.Please detail your recommendation for improvements to the 'Introduction' section of the framework here.

At the heart of our suggested improvement lies the definition of professional and supporting technical roles.

It is critical that we define honestly and diligently what is meant by a professional role and what is meant by a supporting technical role.

The introduction acknowledges “the symbiotic relationship of the pharmacy technician and pharmacist complements and supports the work of the GP …” but in order to do this there needs to be adequate and honest role definition based on underpinning clinical knowledge and competency.

We agree that there are workforce challenges in the healthcare sector and that the way forward is to develop skills of all the non-medical force. We support this concept and would agree that technicians should support the role of pharmacists, just as pharmacists support the role of the GP, to enhance patient care.

However, the bulk of the NCF outlines specifications which are far beyond the remit and competency of pharmacy technicians, especially newly registered technicians.

Defining professional and technical roles :

The term “pharmacy professional” is being applied to technicians as a noun rather than as a verb “being professional”. All pharmacy team members must “be professional” but that in itself does not make them “a professional”.

This distinction is underpinned by the huge difference in education between the 4 year full time, level 7 MPharm degree compared to the workplace based level 3 education and training of a technician.

The latest Skills for Health update in March 2019 (6) , which took into account the current IET for pharmacy technicians set by the GPhC states its intention to develop this level 3 qualification :

> ***“Commissioned by Health Education England (HEE), the development has brought together seven awarding organisations to collectively develop a new level 3 diploma for the pharmacy technician workforce.”***

The introduction needs to make clear that the IET of pharmacy technicians is to a level 3 technician standard. This is the baseline we need to start from.

It is also important to note the variation in courses and also that the majority (61%) of pharmacy technicians are currently on the register having entered via the grandparenting route (3) with no record of the course that they may have passed to actually be on the register.

The introduction also notes that The APTUK is committed to:

> ***"promote the pharmacy technician profession, foundation and advanced roles .."***

However, the APTUK website only has a foundation framework which is visible. (7) The website states that the advanced framework is ***"under development".***

The APTUK Website (7) also states:

> ***"The APTUK Foundation Pharmacy Framework is comprised of the following components or clusters:***
>
> ***Patient and Pharmaceutical Care***
> ***Professional Practice***
> ***Personal Practice***
> ***Management and Organisation***
>
> ***Each cluster has been designed to provide competences that reflect generic roles and responsibilities undertaken by pharmacy technicians who are in the early years (foundation) of their careers. It is designed to build on the competences that pharmacy technicians have already been assessed against in the entry qualification. In my opinion this is the first piece of work that will support Pharmacy technicians in the one of two years post registration, covering a range of practice areas and home countries (Wales and Scotland)– Tech services, CCGs, Dispensing Drs, Community, Hospital."***

Within the detailed foundation framework, the APTUK states:

> ***" Other National Frameworks for example Final Accuracy Checking or Medicines Management currently sit in the advanced practice section. The APTUK FPF will provide a stepping-stone to these areas of practice, supporting pharmacy technicians with their development from foundation practice to advanced practice. "*** (8)

This NCF is heavily focused on medicines management and clinical roles which the APTUK itself recognises are an advanced practice. However, later in the ***"application of the NCF"*** section, it is suggested that training in enhanced clinical knowledge is optional and needs no assessment.

Any reader of the NCF would assume that any pharmacy technician (even one who has just completed their level 3 qualification) could be offered a position within a GP surgery and trained to undertake complex clinical work within the proposed timeframe of 18 months.

The University of East Anglia report on roles of pharmacy technicians (2) recognised the priority need for clinical training required if pharmacy technicians were to make career progressions.

This APTUK framework fails to recognise the importance of this.

https://www.uea.ac.uk/documents/899297/15294873/Identifying+The+Role+Of+Pharmacy+Technicians+In+The+UK/d6d60e7b-f527-481a-8f16-9f3f04037b6c

Table 67: Priorities for Training

Technical	Clinical	Management	Training
ACPT H, C, O Attend National Framework Courses H More CPD/conferences to maintain and update knowledge H AMITTS scheme H I.V. qualification H ILM level 2 H, O Closer work with pharmacists and structured training H Use of PGDs H Medicines Management (MM) H, PC, GP, MMAP C, O	Patient counselling & consultation H, PC, O EHC C Asthma reviews C, PC Inhalers C Stoma management PC Communication H Clinical training H, C, PC, GP, O Clinical diploma PC, GP Clinical diploma (but not one that has to be completed in hospital pharmacy) H PTQA H Training on certain groups	Management masters H High level management training H Management course C, PC, O HNC in Pharmacy Services Development and Management H, GP More soft skills like shadowing the director for capacity H Management degree H Finance- related qualification H Managerial & General H Clinical Research Design H	NVQ assessor training H, C External verifier training and IQA training H, O Training for teaching H, C, GP Revalidation H In-house training GP, O In-house training on wards and in community to be proactive in making the discharge from hospital smooth PC A1/A2 assessor's course PC

The University of East Anglia report (2) noted verbatim many comments by technicians. One strikingly honest comment was:

> **"There was discussion amongst group members about what the PT role was supposed to be. Most said they had come into the job because the technical bias of it appealed to them. This PT summed it up:**
>
> **"That's why we're called technicians; we used to be called medical technical officers because technical detail is what we do, you know. We're not…it's not that we're not interested in clinical but technical detail is our remit."**

We would contend that many other technicians have also exhibited the honesty to recognise the limitations of their initial education and training. This is to be applauded as it reduces patient risk from technicians being asked to undertake tasks that they are not equipped to undertake.

As a straightforward illustration, the National Occupational Standards (NOS) applicable to pharmacy technicians require adherence to standard operating procedures at all times, whilst the responsibility for establishing, maintaining and reviewing them rests with the pharmacist.

The NVQ level 3 diploma for pharmacy technicians specifically assesses: "4. apply knowledge of standard operating procedures (SOPs) adhering to them at all times." (9)

In marked contrast, the 2008 Pharmacy regulations specifically notes the responsibility of the pharmacist: "The Medicines (Pharmacies)(Responsible Pharmacist)Regulations 2008:Guidance"

> ***Where a pharmacist is in charge of a pharmacy, s/he also has a legal responsibility to secure safe and effective working in the pharmacy. In complying with the legal duty, the responsible pharmacist is required to set out procedures for safe and effective working in the pharmacies. This supports the professional requirement on pharmacists to ensure there are Standard Operating Procedures (SOPs). Thus, the responsible pharmacist is legally and professionally accountable for the pharmacy procedures.***

Whilst these regulations relate to registered pharmacies, the central role of the pharmacist in setting out safe SOPs is clear.

Health Education England in 2019, charged with training provisions for the pharmacy workforce made a notable distinction in its "Medicines Optimisation in Care Homes Training for Pharmacy Professionals".(10) It noted the clear distinction in roles of a pharmacist and the pharmacy technician following 18 months of supervised training for both roles :

> ***"On completion of their training, pharmacists will be able to work in these settings as part of a fully integrated multidisciplinary team in a patient-facing role to clinically assess and care for patients using their expert knowledge of medicines. Pharmacists will become independent prescribers. They will work with and alongside the multidisciplinary team to care for patients with chronic diseases (amongst others) and undertake clinical***

> ***medication reviews to proactively manage people with complex polypharmacy, especially those with multiple co-morbidities. They will provide specialist expertise in medicines use while helping to address both the public health and social care needs of those patients.***
>
> ***<u>Pharmacy technicians</u> will be able to review patients and identify patients who need further pharmacist or multidisciplinary review. They will also handle medicines reconciliation upon admission and during transitions of care to/from the care home or place of detention for those working in the Health and Justice sector. The pharmacy technician may attend the ward rounds and be the link into the multidisciplinary team in conjunction with the pharmacist."***

Similarly, the recent CPPE course (11) for pharmacy technicians, funded by Health Education England stated:

> ***"By the end of the pathway pharmacy technicians will be able to review patients and identify patients who need further pharmacist or multidisciplinary review.***
>
> ***They will also handle medicines reconciliation during transitions of care and support the work of the pharmacists. Pharmacy technicians will work with all staff and appropriate agencies to establish and develop good management of medicines systems across the primary care network, from ordering to storage, administration, recording, medicines disposal, audit and waste reduction.***
>
> ***Pharmacy technicians will, at all times, promote evidence-based, cost-effective prescribing and seek to improve problematic polypharmacy, safe medicines use and patient outcomes."***

There is no ambiguity in what the pharmacy technician is expected to do when faced with complex situations. Compare this to the NCF which repeatedly states ***"and takes appropriate action"*** which is so ambiguous as to pose a potentially serious health risk for patients. The appropriate action whenever complex medicines management issues are involved should always be "refer to the practice clinical pharmacist or GP"

This NCF would be far better served if it clearly defined (as exampled above) how the symbiotic relationship between the pharmacist and pharmacy technician can be utilised to enhance patient care.

For a more detailed and comprehensive analysis of what constitutes professional and technical roles please refer to the PDA report on the current pharmacy technician landscape and the distinctions between what are technical roles and professional roles.

We will also discuss the IET for pharmacy technicians in detail later.

Section 1 Recommendations :

The Introduction should reflect and acknowledge :

- That the IET for pharmacy technicians needs a radical overhaul
- The existing deficiencies in the underpinning clinical knowledge
- The issue surrounding high percentage of "grandparented" registrants needs to be addressed

Section 2 - Purpose and Use of the Framework

This section is intended to explain the purpose of the framework and how it should be used

9.Do you have specific recommendations for improvements to the 'Purposes and Uses' section of the framework?

(•) Yes

( ) No

10.Please detail your recommendation for improvements to the 'Purpose and Uses' section of the framework here.

We agree that the purpose and use of the NCF needs to be properly and fully defined.

However, it should be predicated on the implicit assumption that every "purpose and use" of each service that is provided should reduce risk of harm for patients. We contend that this framework, as proposed does the very opposite.

We agree that one of the underlying drivers has to be competence. However, the NCF falls short in failing to recognise that competence is underpinned by knowledge and education.

The statement that

> ***"its primary function is to provide a set of core competency standards …"***

is clearly not correct.

The APTUK has published its foundation level framework but has failed to publish the advanced level framework for technicians. This further highlights why this proposed NCF is premature and seems designed to carve out positions for technicians in primary care that are not underpinned by education, competence or training.

One of the purported purposes of the NCF is to:

> ***"inform the development of job descriptions and role specifications for primary care pharmacy technicians"***

However, within the PCPA website, there are clear specifications and roles listed for Band 5, Band 6 and Band 5-6 GP based pharmacy technicians. The purpose of the NCF would be better served if it was aligned to these role specifications.

A further purpose listed is:

> ***"provide a basis for discussions around the development of pharmacy technicians to work at an advanced level …"***

As we read through the NCF, it becomes clear that this is the ***primary and main*** aim.

Given the considerable variation in how the IET for pharmacy technicians is delivered and the ensuing inconsistency of assessment, this NCF needs to be focused on alignment with the foundation level standard of work that every

technician must reach before some of the highly advanced clinical roles can be entertained.

Even with the pharmacist university courses we have witnessed that following graduation, a pre-reg exam is required to assure a uniform standard for entry onto the register. Recent pass marks of around 70% for pharmacist graduates implies that a similar quality assurance examination is also required for pharmacy technicians.

At present, there is no such quality assurance for entry into the pharmacy technician register, and the GPhC IET (13) notes:

> ***"Pharmacy technician education is flexible in its delivery. The standards combine both knowledge and competency elements, to allow trainees to learn based on experience of clinical, operational and scientific practices and procedures. As such, it can be delivered face-to-face, at a distance, online or a combination of these and the standards apply to all these delivery methods."***

Education providers or training programmes cannot be so diverse as to accommodate learning objectives when the baseline of entry is so weak and thus diminished. The starting point has to be a quality assured entrance onto the GPhC register.

Thus, as a minimum, all pharmacy technicians must take a national exam which should be set and moderated by the GPhC in order to work at higher competency levels within any setting including primary care. This would effectively become a "pre-reg" exam akin to the quality assurance exam used for all pharmacy graduates who must pass this exam in order to enter the register of the GPhC.

From this starting point, those technicians who wish to, can then embark onto a foundation level of training and development. They would then need to undergo a robust assessment process before progressing to advanced practice.

The APTUK in association with relevant stakeholders would need to devise a framework for this advanced practice which too would be assessed by a robust independently assessed process Each stage of this process needs to be quality assured to a consistent standard by way of uniformly structured examinations.

We use the word “robust” as there is some evidence of plagiarism and cheating with course-based assessments during the IET and further details can be found in reference (3).

The hospital sector, often referred to as secondary care, provides an excellent template of how technicians and pharmacists have worked symbiotically (as the NCF purports to want in primary care). The interests of technicians would be better served if this model of structured and rational shared responsibility became the ultimate aim of the NCF and indeed facilitated this.

The central purpose of this framework and thus its “purpose and use” could then focus on how the symbiotic relationship between pharmacist and pharmacy technician could evolve.

This NCF seems to want to bypass due process in its rush to landgrab as many roles as it can for a membership which is not adequately trained or ready.

Section 2 (Purpose and use of NCF) Recommendations :

- The purpose of the NCF needs radical redrafting so as to reflect the symbiotic relationship between pharmacist and pharmacy technician.
- The suggested use of the framework needs to be more in line with the current education and training of technicians and the limited underpinning clinical knowledge of the IET.

Section 3 - Scope of the Framework

This section is intended to explain the scope of the framework.

11.Do you have specific recommendations for improvements to the 'Scope of the Framework' section of the framework?

(●) Yes

( ) No

12.Please detail your recommendation for improvements to the 'Scope of the Framework' section of the framework here.

Throughout the document, the correct terminology is used for professions such as family doctor, community midwives and practice nurses. There is no reason for community pharmacists to be referred to as ***"chemists".*** Correct use of terminology is important, as it determines who the patients will see or consult for their healthcare needs.

It is clear that there is a significant mindblock in the NCF in recognising that pharmacy technicians will be undertaking work under the supervision or under the guidance of the GP Practice pharmacist (junior or senior level)

The NCF goes on to describe:

> ***"the scope may need to be increased as more roles for pharmacy technicians in primary care evolve and the need to support their professional development by means of an extension to this framework".***

The role for pharmacy technicians as support staff is already clearly defined in the NCF introduction and acknowledges the symbiotic relationship with the clinical pharmacist.

This elbowing out of the pharmacist is apparent throughout the NCF which not once mentions that ***"an appropriate action"*** by a pharmacy technician when faced with a complex situation would be to refer to the practice clinical pharmacist.

The phraseology used throughout the NCF will, if ever adopted, lead to friction between pharmacy technicians who may believe that ***"appropriate action"*** is a

blanket cover all phrase to assume “responsibility” without fully understanding the requisite “accountability” for their actions.

We can highlight the recent surge in clinical pharmacists based in GP surgeries as an example. Even though pharmacists have a robust training many junior pharmacists have struggled to say “no” when asked to assume responsibility for aspects of patient care that were beyond their competency.

Emerging data from the PDA has noted a significant rise in patient critical incidents as more pharmacists have felt pressured to work outside their core competencies and before they have completed an extended level of supervised work.

The lack of insight shown in this NCF has the potential to cause grave harm to patients, especially when seemingly endorsed by a what is grandly titled a “National Competency Framework” and especially given the experience of junior pharmacists who have started working in GP practices.

The scope of the NCF shows a clear intent to move away from the core duties of a pharmacy technician and a move towards the roles occupied by pharmacists without fully understanding the complexities of these roles and the education, clinical knowledge and competencies underpinning each specific role. Even junior, recently qualified pharmacists have struggled in this shared responsibility environment.

This failure of fundamental understanding (given that the APTUK has failed to draft the advanced practice framework) within the NCF is illustrated by:

> ***“The scope of this framework does not incorporate the competencies within different levels of practice such as foundation and advanced practice. The criteria within the competency framework are referred to as ‘core’ criteria. The term ‘core criteria’ within this framework is used to define the set of competencies that represent a ‘baseline’ for pharmacy technician practice in primary care.”***

It is clear that the APTUK is aware of the limitations of current pharmacy technician education and this is admitted in its response to “ Facing the Facts, Shaping the Future A draft health and care workforce strategy for England to 2027 consultation” (14)

> ***"APTUK would also approve of a review of post registration Pharmacy Technician training. We would be pleased to advice on the development of higher level qualifications. Thus providing the educational framework to support advanced roles experienced Pharmacy Technicians may undertake, as part of a wider Multidisciplinary team."***

The APTUK in its submission further acknowledged

> ***"We believe that there must be measurable quality within work-based learning to ensure patient safety and the delivery of high quality care …."***

The issue of public safety is really important and any role enhancement sought by pharmacy technicians must be predicated on safe delivery to patients. A number of studies involving nursing skill mix have shown that there are patient safety issues when a wider skill mix is used.(15)(16) We should not discount the likelihood that the same principles would apply in other healthcare professions.

Given that a much higher level of education is needed for advanced level working, the NCF changes tack and now suggests:

> ***"The framework takes into account the experienced pharmacy technician workforce that may have existing knowledge and skills from other sectors but it is the breadth of application of this knowledge that informs the scope and level of practice in this evolving sector for pharmacy professionals."***

The fact that the consultation document then goes on to state that it takes into account the ***"experienced pharmacy technician workforce that may have existing knowledge and skills from other sectors"*** implies that in reality the core criteria they set out to make are not truly as such; they require additional training and supervised experience with professional mentors.

Section 3 (Scope of NCF) Recommendations :

- The scope should clearly mark out competencies for foundation and advanced practice and align these with existing pharmacist roles.
- A revised "core criteria" should align with foundation practice
- Advanced criteria (mostly taken from the inappropriate core criteria) be aligned to advance practice
- The scope of the wholly revised framework must be based on the role of the technician ***supporting*** the clinical pharmacist who is supporting the GP.

Section 4 - The Competencies

This section outlines the 4 domains of the competency framework and descriptors of the 10 core competencies within the domains.

13.Do you have specific recommendations for improvements to 'The Competencies' section of the framework?

(●) Yes

( ) No

14.Please detail your recommendation for improvements to 'The Competencies' section of the framework here.

We question whether the 4 domains and the 10 inappropriately named ***"core competencies"*** listed are appropriate for this NCF as they are overly ambitious for pharmacy technicians and thus devoid of rational implementation.

By way of a contrast, the 2018 ***"General Practice Forward View (GPFV) Clinical Pharmacists in General Practice Phase 2"*** (17) notes ONLY the following 2 relevant domains for clinical pharmacists:

> ***"1.2. Broadly, learning within the programme can be split into two intersecting and overlapping domains:***
> ***• Clinical learning – understanding service provision, conventions, relevant guidance, tacit knowledge and skills to enable delivery of appropriate primary care – immediate local supervision needed.***
> ***• Professional development – understanding values, responsibilities, relationships and accountability of the pharmacist clinician in general practice/primary care – less immediate, often reflective."***

This graphically illustrates the wholly inappropriate nature of this NCF and the fundamental disconnect between what the APTUK aspires to and what pharmacy technicians can actually deliver given that the IET for pharmacy technicians is at a level 3 standard.

Before we move onto the specific competencies, we can provide an example of a shared symbiotic working between a pharmacist and a pharmacy technician. This is taken from an actual working scenario provided by a CCG and GP based clinical pharmacist.

1/ The clinical pharmacist asks the technician to audit a patient list for all patients on DOACs and record the details specified on a ready provided template.

2/ The list, comprising of many hundreds of patients was passed to the clinical pharmacist who assessed those patients that needed dosage changes or further blood tests or needed to be seen for a medication review. This group of patients that needed these interventions was presented to the GP, as required within the practice SOP, to decide on the next steps.

We have simplified the above to demonstrate how a structured working relationship between the technician the pharmacist and the GP could work to identify and manage high risk patients. At all stages, each individual worked to a structured SOP and within the boundaries of their clinical knowledge and competence and experience.

Moving to each "competency" in a rational way, we discuss our concerns only where the proposed competency poses greatest risk. We have omitted others as they pose lesser risk (this document would become far too detailed if we examined every area of concern):

Domain 1 - Clinical Governance – 1a Professional Practice:

Item (ii) needs to be reworded to recognise the limits of the technician role:

"Practices within the scope of the role and recognises the limits of own knowledge and skills" and add – "whilst recognising the roles of all other members within the multidisciplinary team".

Domain 1 - Clinical Governance – 1b Risk Management:

Risk management is a complex process. There are layers of risk and depending on the exact nature of the process that is being undertaken.

Item ii/ We question whether a pharmacy technician has the required education, training or skillsets to suggest system changes.

Sir Liam Donaldson, in his report ***"Good doctors, safer patients"*** (18) following the seminal Shipman enquiry noted the relevance of robust systems and their impact on patient care:

> ***"A culture of blame and retribution has dominated the approach to this whole field so that it has been difficult to draw a distinction between genuine misconduct, individual failure, human error provoked by weak systems …"***

Changes in systems and processes are complex issues and should not to be suggested in the manner described in this NCF.

Item iv/ Identifying the "cause" of errors is a complex skillset. Any pharmacy technician would first need to only operate under the strictest of SOPs to limit the potential for errors. We would contend that only the most advanced clinical pharmacists would be able to establish "causes" of errors and embed these into training documents to minimise the risk of them occurring.

Item v/ Whilst we agree every healthcare practitioner must be able to identify situations of risk, it is the steps that follow that are critical. The NCF proposes that a level 3 educated technician should manage this risk and ***"escalate if appropriate"*** is wholly inappropriate. Risk management when patient safety is concerned must always involve the clinical pharmacist and only the most senior of technicians with advanced training may be able to perform this.

This goes to the heart of the failure of the NCF to adequately understand the nature of risk and how it must be minimised to ensure the safest possible care for patients.

~~"Identifies and manages situations of clinical risk within scope of own competence and escalates if appropriate"~~

The appropriate wording would be:

"Supports the pharmacist to identify and manage situations of clinical risk whilst working under a written SOP and escalates situations identified in SOP or where uncertainty exists, to the clinical pharmacist."

Domain 2 – Person-Centred Care – 2a Communicating Effectively

Item i/ The last bullet point suggests that the technician should "provide personalised care". If we think about this, personalised care is so individual that no SOP could cover all the possibilities. At foundation level, technicians will not have the clinical underpinning knowledge to be able to undertake such personised care and must not be led into believing that they can do so.

We can again turn to a specific situation to highlight how the pharmacy technician would use their "communication skills" within defined shared responsibility multidisciplinary working

1/ The pharmacist asks the technician to audit and identify all patients on a certain inhaler.

2/ The audit list is passed to the clinical pharmacist who decides, based on patient history, individual patient knowledge and other criteria those patients that may be suitable for a switch to the alternative inhaler.

3/ That list is passed to the technician to contact patients individually to manage the switch. Considerations that may be within the SOP for the technician could be:
i/ patient age and need to be shown how to use new inhaler
ii/ patient acceptance of switch and next steps if showing reluctance to switch
iii/ follow up after 14 days to check how patient is managing with the switch – the follow up may include checking patient inhaler technique where appropriate.

Domain 2 – Person-Centred Care – 2b Supporting Structured Medication Review

A structured medication review is a complex undertaking. The term ***"support"*** is used in the title but the detail actually seems to suggest that the technician may start taking ***"appropriate action"*** . This is wholly inappropriate.

We can compare how the PCPA has worded the process for an entry level junior pharmacist in relation to medication review (1):

> ***Undertake clinical medication reviews with patients and produce recommendations for the GP on prescribing and monitoring.***

It is clear that even junior pharmacists must refer these complex matters to the GP for sign off. This whole section within the NCF is worded so poorly as to have the potential to cause serious patient harm.

In every case, the ***only*** appropriate action would be to refer to the clinical pharmacist. The mindblock within the NCF of the role of the clinical pharmacist and the refusal to acknowledge that this is the person a technician ***must*** refer to shows a framework with potential to cause serious patient harm.

A structured medication review is a professional role, it is not a technical role and involves complex decisions taking into account many disparate considerations but is always underpinned by high level clinical knowledge (see previous comments on the distinction of roles).

We agree that a suitably qualified technician may, under a working SOP, be able to do some preparatory work for the clinical pharmacist to undertake the structured medication review.

Item iii/ of this supposed "core competency" :

"Identifies unnecessary duplicate or similar repeat medication items and takes appropriate action"

What possible appropriate action would this be? On what assumption is the term "unnecessary" used? Is deprescribing being suggested?

The ***only*** appropriate action is highlighting the duplication for referral to the clinical pharmacist.

Item v/ A standard operating procedure cannot appropriately be used for this purpose. There are a plethora of reasons why a medicine may not be used appropriately and each situation may have a unique nuance. The suggestion that a SOP is used goes against competency (2a) which mandates personalised care.

Item vii/ similarly states:

"Takes appropriate action relating to necessary monitoring requirements"

There is no appropriate action ***other than*** referral to a clinical pharmacist ***any*** issue pertaining to monitoring. The subsequent action would be decided by the clinical pharmacist using his clinical knowledge.

Thus, whilst a technician should identify patients that may require a blood test it would be wholly inappropriate for them to take subsequent action to continue or vary or discontinue treatment.

Domain 2 – Person-Centred Care – 2c – Polypharmacy and Deprescribing

This is a complex area and a very advanced competency. We agree that technicians need to understand an explain the terms.

However, to ensure patient safety this must be contextualised so that the technician understands that this complex area needs advanced practitioners to carry out safely.

Deprescribing is the opposite of prescribing. It sounds very simple but carries a magnitude of risk that has the potential to cause serious patient harm.

It is beyond the scope of this document to explain the complexities of prescribing and the underpinning clinical knowledge required. Deprescribing is as complex as prescribing and requires the same level of underpinning clinical knowledge.

Domain 2 – Person-Centred Care – 2d – Effective problem solving and Decision making

We agree that not every simple measure needs the intervention of a clinical pharmacist or a GP. That would be counter-intuitive and a waste of precious resources. However, there must be an explicit understanding that decision making is a complex skill and could have profound consequences.

Item i/ states:

"Makes appropriate decisions using professional judgement and ensures that the care of the person is the first concern"

Should be replaced with:

Makes appropriate decisions using ***appropriate*** judgement ***within the boundaries of a defined SOP*** and ensures that the care of the person is the first concern.

Item iii/ We especially agree that a core competency ***must*** be for technicians to ***"recognise limits of authority and knowledge"*** as mentioned in item(iii). The wording throughout this NCF is unhelpful when considered in context with this competency.

Domain 3 – Medicines Optimisation – 3a – Access, Use and Maintenance of Patient Records

GP practices and everyone who works within the setting rely on accurate records. This is a critical patient safety issue.

Item iv/v We agree that technicians should be able to update patient records and make necessary changes. We disagree that ***"seeking approval where required"*** is appropriate as a core competency. Changing records could have profound implications far beyond the training and scope of an entry level technician even once their training is complete. This skill requires a level of cognisance that can only be considered an advanced competency. Items (iv) and (v) need to be reworded in toto and contextualised for a technician to operate safely.

Thus, an overarching caveat of "as defined within the SOP" should apply and "seeking approval where required" falls away. Any issue outside of the SOP would then be referred to the clinical pharmacist.

Item vi/ The PCPA guide (1) for management of medicines at discharge from hospital states for junior entry level pharmacists:

"To reconcile medicines following discharge from hospitals, intermediate care and into care homes, including identifying and rectifying unexplained changes and working with patients and community pharmacists to ensure patients receive the medicines they need post discharge."

We are unclear what "manages" means for technicians when this complex task is already being performed by a junior entry level pharmacist. Is the technician role to replace the junior pharmacist? Does this competency suggest that the current role being performed by a highly trained but junior level pharmacist can be easily substituted by a level 3 educated technician?

Earlier, we alluded to the fact that unless the NCF acknowledged adopted a "shared care" mentality, there would be friction with the clinical pharmacist. This point is perfectly illustrated by the above proposed competency (vi).

We reiterate our support for technicians to develop meaningful and fulfilling career development. However, this is within the context of patient safety, working within professional boundaries and also within the scope of the underpinning clinical knowledge.

Point (vi) within this NCF is nothing more than boundary setting to elbow out the valuable skillset of the junior clinical and even senior pharmacist.

Item vii/ The word "resolves" is vague and ambiguous. At the foundation level, a technician should always resolve by referring to the clinical pharmacist (junior or senior) and/or the GP. This is the only way to ensure safe practice.

Domain 3 – Medicines Optimisation – 3b – Medication Supply Processes
The medication "supply" process, whilst seemingly simple and straightforward holds many dangers especially if undertake with limited underpinning clinical knowledge.
There are too many individual points to discuss and it would be repetitive and counter-productive to go through all of them.

In toto, we suggest that use of words such as "manage", "appropriate action", "interpretation" etc be considered and place in context of a technician assuming responsibility and legal accountability (including criminal sanction) for the supply process.

As an example of the inappropriateness of this section we can see from a few examples:

Item x/ "Identifies inappropriate use of medicines suggesting possible medication issues, including excessive usage or under usage"

What possible use is identification if it is not followed up with a referral to the clinical pharmacist?

Item xi/ This item suggests that a core competency (note not an advanced competency) for a technician should be to take "appropriate action regarding follow up and interpretation of patient specific results in line with SOPs". The results of a blood test may seem innocuous to an inexperienced technician. However, when requested as part of a diagnosis assessment the technician may not understand the implications of a single blood test and its context.

I**tem (xii)** similarly seems unable to use the expression "refer to clinical pharmacist" when this would be the most appropriate next step.

Item xvi/ states “Manages medicines no longer required or not suitable for use”. What does manage mean?

What should be stated in a proper symbiotic relationship between pharmacist and technician is :

“Identifies medicines no longer required or not suitable for use and refers this to the clinical pharmacist”

Domain 3 – Medicines Optimisation – 3c – Clinical Knowledge and its application.

We have already discussed the limited clinical knowledge that underpins the IET for all technicians.

A recent report by the University of East Anglia (UEA) (2) noted the following views of technicians when asked how they could expand their roles within GP settings (the passages in inverted commas are verbatim quotes from technician):

> ***A desire for expansion into more clinical roles was expressed and this would require more clinical knowledge and training.***
>
> ***“It would be good to see pharmacy technicians doing more clinical roles. We would need relevant training but I feel as a profession we are capable of taking that on.”***
>
> ***“I think our current role could be expanded by getting more clinical knowledge.”***

The career framework within hospitals is far more advanced than any other area of practice for pharmacy technicians. Even hospital trained technicians understand the limitations of the underpinning clinical knowledge that the IET for technicians course requires (from UAE report):

> ***There was discussion amongst group members about what the PT role was supposed to be. Most said they had come into the job because the technical bias of it appealed to them. This PT summed it up:***
>
> ***“That’s why we’re called technicians; we used to be called medical technical officers because technical detail is what we do, you know. We’re not…it’s not that we’re not interested in clinical but technical detail is our remit.”***

It is significant that the then president of the ATPUK was a named co-author of this report.

We would suggest that ***this whole section is deleted as a core competency***. In light of existing training and the need for post registration education this whole competency must never be classed as a core competency.

Domain 3 – Leadership – 4a – Demonstrate leadership.

This cannot be considered a core competency. It is advanced practice and whilst junior level technicians must aspire to and work towards assuming greater structured responsibilities this section should be re-titled as "working towards demonstrating leadership within scope of role"

Grass root technicians recognise that leadership training and facilitating is needed when asked how their careers could progress (14)

> ***Increased clinical and leadership skills were identified as important facilitators.***
> ***"More clinical content in syllabus. More leadership skills."***

15.Do you agree that the 4 domains that underpin the competencies (clinical governance, person centered care, medicines optimisation, leadership) are the correct domains to use?

This question is related to section 4.1 - Competencies within the Domains section of the framework

- ○ Yes
- ◉ No
- ○ Don't know

16.Please give detail of what you disagree with regarding the 4 domains

Domain 1 : Clinical Governance
We note the absence of standard 2 which states:
"Pharmacy professionals must work in partnership with others"

It is apparent throughout the NCF that the technician is being encouraged to work autonomously and without partnership with others. The perfect illustration is the omission of standard 2 when it should underpin ***ALL*** professional practice.

Domain 2 : Person Centred Care
We cannot understand how person-centred care can meaningfully be provided in the absence of standard 4.
Standard 4 should be added: “Maintain, develop and use their professional knowledge and skills”

Domain 3: Medicines optimisation
These standards are also important -- for example a person may experience side effects when their medicines are "optimised" -- so the need to speak up when things go wrong is important. Similarly you cannot "optimise" care unless you have maintained your professional knowledge.
Standard 4 should be added: “Maintain, develop and use their professional knowledge and skills”
Similarly, when optimising medicines there may be conflict.
Standard 6 should be added: “Behave in a professional manner”

Domain 4 : Leadership
Leadership cannot be achieved by saying " I am a leader" or " I want to be a leader". Leadership involves being able to communicate well.
Standard 3 should be added: “Communicate effectively”
In clinical settings, those that are most informed and can demonstrate leadership, for example by evidencing proposed changes to formularies would be able to lead on this. Thus this would be important.
Standard 4 should be added “Maintain, develop and use their professional knowledge and skills”
Similarly, leaders would be expected to behave in a professional manner.
Standard 6 should be added: “Behave in a professional manner”

17.Are there any domains missing?

- ○ Yes
- ◉ No
- ○ Don't know

18.Please give detail of what you feel is missing from the domains.

Please refer to our comments to earlier questions.

19.Would there be any barriers in the application of these core practice criteria to your setting, country, area of practice?

- ◉ Yes
- ○ No
- ○ Don't know

20.Please give details of any barriers

We note that the NCF has not acknowledged that technicians are only registered in GB and not across the UK.

To avoid repetition on other issues please refer to our earlier comments in response to earlier questions.

21.Do you agree with the mapping of the 4 domains that underpin the competencies (clinical governance, person centered care, medicines optimisation, leadership) to the GPhC professional standards?

This question is related to section 4.2 - Mapping of Competencies to Professional Standards section of the framework

- ○ Yes
- ◉ No
- ○ Don't know

22.Please give detail of what you disagree with regarding the mapping of the 4 domains underpinning the GPhC professional standards

Please see our detailed response to earlier questions.

Section 4 - Competency Recommendations :

- This whole section on competencies needs to be deleted and replaced within the proper context of foundation and advanced practice
- The foundation competencies should be structured to work symbiotically with junior clinical pharmacist roles
- The advanced competencies should be structured to work symbiotically with senior clinical pharmacist roles
- Substitute “appropriate action” with “referral to a clinical pharmacist or GP”
- The section should be renamed : “Supporting structured medication review under the direction of named clinical pharmacist”.

Section 5 - Application of the Framework

This section is intended to be clear on how Primary Care Pharmacy Technician Training Programme/Course providers apply the framework in the development of their provision.

23.Do you have specific recommendations for improvements to the 'Application of the Framework' section of the framework?

(●) Yes

( ) No

24.Please detail your recommendation for improvements to the 'Application of the Framework' section of the framework here.

The document has failed to note that technicians are not on a PSNI register and that the legal requirement for registration is only in GB and not across the UK.

There is an implicit assumption that a registered technician, having entered the register via a grandparenting route, would be able to undertake the tasks proposed in this NCP.

We also note that the terminology ***"appropriate supervision"*** is used. The GPhC has allowed the supervision of a level 3 pharmacy technician course by a registered technician. However, this NCF (or the suggested revised NCF) is totally outside the scope of the supervisory and mentoring capacity of most technicians.

We suggest that the wording be amended to reflect that appropriate supervision must be by a senior clinical pharmacist or GP in addition to other education and mentoring supervisors (see later section comment)

25.Do you agree with the application and entry criteria?
This question is related to section 5.1 - Application and Entry Criteria section of the framework

- ○ Yes
- ◉ No
- ○ Don't know

26.Please give detail of what you disagree with regarding the application and entry criteria

We do not agree with the entry criteria.

There is an implicit acknowledgment of the limitations of technician clinical knowledge, their qualifications and their experience.

This seems to be implicitly recognised in the requirement for ***"safe processes to be in place"*** and the technician to have access to ***"current SOPs and or protocols that detail their roles and responsibilities."***

The acknowledgment is not at all clear in the preceding (and subsequent) pages of the NCF and we recommend that these limitations are explicitly highlighted throughout the framework.

The IET for technicians is wholly inappropriate even when working within the most rigorous of SOPs and we would recommend a post registration pharmacy technician clinical knowledge diploma as a minimum requirement for an entry level position within a GP setting.

There are courses such as “The Certificate in Medicines Management for Pharmacy Technicians” which should be a mandatory entry point.

However, many courses seem to appear and disappear and the lack of clear guidance from the GPhC is unhelpful. For technicians to make meaningful progress there has to be a clear pathway and one which is robust and resilient.

27.Would there be any barriers in the application of the application and entry criteria in your setting, country, area of practice?

- (●) Yes
- ( ) No
- ( ) Don't know

28.Please give details of any barriers

The biggest impediment to the safe application of this NCF is the IET of pharmacy technicians.

This level 3 education is not sufficient to prepare technicians for undertaking or assuming more complex roles within any clinical setting. The APTUK needs to engage with policy makers to start the process of making available courses that would enable technicians to make career progression in a structured manner.

29.Do you agree with the management plan and learning agreement?

This question is related to section 5.2 - Management Plan and Learning Agreement section of the framework

- ( ) Yes
- (●) No
- ( ) Don't know

30.Please give detail of what you disagree with regarding the management plan and learning agreement

This is a confused page. It is unclear who the target audience is. Is it education providers such as universities or colleges? Is it local hospital trusts? Is it the CCG or STP? Is it the GP surgery manager who will draft the contract with the technician and part of this contract would be to enrol the trainee on a suitable course?

We recommend that the APTUK gives some more thought to this and reconstructs this page and make it relevant for specific audiences.

We are also concerned that that the NCF fails to understand that such a complex proposed framework with such complex competencies needs to structure adequate and relevant supervision and mentoring.

We are concerned at the absence of mentoring throughout the NCF. For technicians to develop their roles, mentoring by a suitably qualified pharmacist or GP is essential.

As a direct comparison the "NHS England Clinical Pharmacist – Guidance on Supervision of Clinical Pharmacists" (17) specifically requires:

- ***A GP clinical supervisor***
- ***A Linked Senior clinical pharmacist***
- ***A CPPE (Centre of Postgraduate Pharmacy Education1) Educational Supervisor***
- ***A clinical mentor appointed by CPPE***

31.Would there be any barriers in the application of the management plan and learning agreement to your setting, country, area of practice?

(•) Yes

( ) No

( ) Don't know

32.Please give details of any barriers

Please see our reply to question 30.

33.Do you agree with the Monitoring and Evaluation?

This question is related to section 5.3 - Monitoring and Evaluation

- ○ Yes
- ◉ No
- ○ Don't know

4.Please give detail of what you disagree with regarding the monitoring and evaluation

There is no detail of frequency of monitoring nor on next steps if the trainee is performing to a standard that poses patient risk.

There is a requirement of a minimum 3 reviews by the education supervisor on a proposed 18-month pathway. The lack of involvement in the monitoring and evaluation process by senior clinicians such as the GP or a senior clinical pharmacist is worrying.

The lack of detail is cause for concern as there could be courses with widely divergent monitoring and evaluation process as a direct consequence of the lack of detail.
We suggest a total redraft with comprehensive detailed monitoring and evaluation information which as a minimum must include monthly discussions with the supervisors, mentors, senior clinicians and specifying robust documented monitoring and specifying a more detailed evaluation process.

35.Would there be any barriers in the application of the Monitoring and Evaluation section to your setting, country, area of practice?

- ◉ Yes
- ○ No
- ○ Don't know

36.Please give details of any barriers

Please see our answer to question 34.

37.Do you agree with the programme/course design and delivery section?

This question is related to section 5.4 - Programme/Course Design and Delivery

○ Yes

◉ No

○ Don't know

38.Please give detail of what you disagree with regarding the programme/course design and delivery section

We have already discussed the lack of clarity in the NCF. The programme and course design can only occur with clarity that there are stages to the development of a pharmacy technician.

The APTUK itself recognises that there needs to be a foundation framework and an advanced framework so that technicians can progress along a structured and safe path.

It would be impossible to construct a programme which delivers advanced practitioners as this framework clearly is seeking to do in one huge step.

There is significant evidence of plagiaristic activity for the IET pharmacy technician courses. The NCF merely suggests the use of "initiatives" to counter inadvertent or deliberate plagiarism.

The NCF also suggests courses should ***"Align with the responsibility and accountability of the primary care pharmacy technician role ".*** The failure to set out clearly defined roles such as foundation/entry level technician or advanced practitioner level is a hinderance and barrier to course design and delivery.

What is really shocking is that training course providers ***"could"*** (as opposed to MUST) design courses with "Enhanced clinical knowledge and skills related to practice". Further, the NCF specifies that this aspect would ***not*** require any assessment.

It is deeply concerning that this NCF is proposing clinical pharmacy technician roles without appropriate levels of underpinning clinical knowledge having been either studied or examined.

It would be impossible to design a course to upskill a technician to the level of competence suggested by this NCF. As such, this whole section is rendered obsolete and is of little value in creating a logical structured pathway for career progression.

By being overly ambitious, the APTUK is actually holding back progress for its paid up members.

39.Would there be any barriers in the application of the programme/course design and delivery section to your setting, country, area of practice?

- (●) Yes
- ( ) No
- ( ) Don't know

40.Please give details of any barriers

Please see our reply to question 38.

41.Do you agree with the access to assessment section?

This question is related to section 5.5 - Access to Assessment

- (●) Yes
- ( ) No
- ( ) Don't know

42.Please give detail of what you disagree with regarding the access to assessment section

We fully support unencumbered access (or relevant and specified adjustments) to anyone who is suitably qualified for any course.

43.Would there be any barriers in the application of the access of assessment section to your setting, country, area of practice?

- ○ Yes
- ◉ No
- ○ Don't know

44.Please give detail of any barriers

We are unaware of any situation where access would be legally restricted.

45.Do you agree with the assessment strategy introduction section?

This question is related to section 5.6 - Assessment Strategy Introduction

- ○ Yes
- ◉ No
- ○ Don't know

46.Please give details of what you disagree with regarding the assessment strategy introduction

Given the highly inappropriate scope of this NCF and the level of knowledge and skills that a trainee would need to learn, there is a grave risk of widespread plagiarism and cheating. There is evidence that this has already been occurring with the level 3 technician qualification. The assessment strategy can only be fit for purpose if the underlying course specification is also fit for purpose.

The NCF states :

> ***"This assessment strategy has been produced to ensure that the assessment of competence for pharmacy technicians undertaking education & training programmes are applied in a standardised approach"***

It then goes onto state:

> ***"The assessment strategy also sets out the mix of methods used for assessing knowledge and competence and outlines a mix of assessment methods"***

We agree that the very first step in ***any*** assessment strategy should be to ensure consistency.

As we have seen with the Schools of Pharmacy, even though they all follow a tightly regulated curriculum, the measurable outcome of the pre-registration exam clearly shows huge variance between course providers.

Given that this evidence is already known, we find it worrying that the NCF does not acknowledge that there may be variances in the quality of course delivery, workplace environment, tutor support and other such issues and it fails to provide any strategic guidance on how it would propose that these matters were addressed.

The issue is compounded by proposing a "mix of methods" which will inevitably be applied inconsistently. The lack of detail for course providers poses a grave risk for a large variance in course quality.

There should be only one assessment method across all training providers and each trainee would be independently assessed. These assessments would then need to be independently audited to ensure consistency.

47.Do you agree with the assessment section?

This question is related to section 5.7 - Assessment

- ○ Yes
- ◉ No
- ○ Don't know

48.Please give details of what you disagree with regarding the assessment section

The assessment section lacks detail. For example, it states that ***"education supervisors are appropriately selected"*** is far too vague.

As a direct comparison, the "NHS England Clinical Pharmacist – Guidance on Supervision of Clinical Pharmacists" (17) specifically requires trainee clinical pharmacists to be supported by a senior clinical pharmacist with a minimum of 5 years of experience.

The NCF also states that any person registered with the GPhC or PSNI could become a supervisor. Given the lack of clinical education and clinical knowledge that the IET for pharmacy technicians provides for, it becomes clear that it should only be a clinical pharmacist or GP that would be in a position to provide the requisite level of education supervision.

This would automatically be the case in Northern Ireland as the PSNI does not have a technician register.

The assessment specification requires: ***" The ability to effectively review a pharmacy technicians entire portfolio …".***

This is a complex task and is consistent with the failure apparent in this NCF to recognise the skills and training of senior clinical pharmacists or GPs for this review role.

Who else in a primary care GP setting would be competent to assess this portfolio?

We are also concerned about the wording ***"credible experience".*** Experience underpinned by education and knowledge and a minimum level of GP practice based experience at ***senior*** level must be a pre-requisite for any education supervisor.

We also suggest better clarity on the use of could, should and must and that the terminology be consistently applied.

49.Do you agree with the requirement for training programmes/courses to span a maximum training period of 18 months?

- ○ Yes
- ◉ No
- ○ Don't know

50.Please give details of what you disagree with

The NCF does not specify a minimum number of hours (each week) that a technician would need to be based in the GP surgery to undertake the training.

There ***must*** be an underlying presumption that to upskill a technician to undertake ***some*** of the symbiotic tasks with a clinical pharmacist, would require the technician to be working a certain number of hours.

A figure of 18 months appears to be arbitrary and within such a short timeframe there is no possibility of covering the "core competencies" as suggested in this framework.

The timeframe would need to be reconsidered once a realistic NCF is proposed.

51.Please give detail here if you know of any circumstances for which the requirement for a maximum 18-month training span could be relaxed

Please see our comment above.

Section 5.8 Source of Evidence

This section outlines the types of evidence that programmer/course providers should include in the assessment strategy of their programme/course delivery

52.Do you have any suggestions for improvements to the workplace observation of practice?

Check the yes option if you wish to give comment on the specific requirements for inclusion of programme/course assessments, assessment methodology, minimum workplace observations or the competencies observations should cover.

(●) Yes

( ) No

53.Please detail your improvements to workplace observations here.

We disagree with the statement that evidence ***should*** be gathered wherever possible from work. The word to be used is ***must.***

A framework ***must*** be specific and detail precisely what is required in order to demonstrate satisfactory compliance with it. Evidence to demonstrate a level of competency sufficient to meet the core standards ***must*** be gathered from work through case studies and peer to peer teaching.

The NCF states ***"Direct observation must be undertaken by the education supervisor or a registered healthcare professional with occupational competence in the area being assessed."*** In order to assure quality and consistency it must always be a senior clinical pharmacist or GP that undertakes direct observation.

Situations could arise where a multitude of "others" undertake this role (all to varying standard) and a pattern of consistent concern are not adequately observed.

Having one supervisor undertaking ***all*** direct observations will enable patterns of learning and concerns to be addressed. GPs and senior clinical pharmacist supervisors will have the requisite skills to undertake ***all*** direct observations.

We are also especially concerned with the following:
"The observation of performance ***could*** relate to a specific activity or provide a more holistic view of the pharmacy technicians performance as it covers a range of work responsibilities."

Sign off for a specific competency can only happen if that competency is demonstrated and observed. The term "holistic" is wholly inappropriate in context of assessing specific competencies to assure quality.

However, our biggest concern is the wording:

"Performance observed is formally recorded by the education ***supervisor/assessor*** and used as part of the overall assessment for the competency and/or wider competencies within the domains"

This clearly leaves the option of the education supervisor also being the assessor for the technician trainee. This is not advisable and the roles of education supervisor and assessor must be separate and distinct.

54.Do you have any suggestions for improvements to the witness testimony?

Check the yes option if you wish to give comment on the definition of who can act as a witness, the specific requirements for inclusion of witness testimony, the minimum number of witness testimonies and which competencies they cover.

(●) Yes

( ) No

55.Please detail your improvements to the witness testimony here.

This section is very vague. If a patient testimony is admissible as evidence under any domain, as suggested, this can lead to a false level of assessment. Going by this statement, a patient could write a witness statement about a technician which could come under the domains of leadership or clinical governance. This is not a robust way to measure competence.

The wording in the NCF ***" .. feedback from patients to be used to support demonstration of competence …"*** clearly has substantial scope for variance.

Patient feedback for certain areas of competency such as ***"Responds sensitively with patients/carers emotions and concerns"*** under domain 2 are appropriate but the NCF needs to detail specific competencies and domains where this may be used.

56.Do you have any suggestions for improvements to the reflective accounts?

Check the yes option if you wish to give comment on the requirement for inclusion of reflective accounts, the requirement for a minimum number of reflective accounts or which competencies they should cover.

(●) Yes

( ) No

57.Please detail your improvements to the reflective account.

We agree, in principle, that reflective accounts ***must*** form part of the assessment methodology.

58.Do you have any suggestions for improvements to the case-based discussion?

Check the yes option if you wish to give comment on the requirement for inclusion of case-based discussion, the requirement for a minimum number of class-based discussion or which competencies they should cover.

(●) Yes

( ) No

59.Please detail your improvements to case-based discussions

We have concerns about both case studies and case-based discussion.

We are concerned that the NCF states ***"Case studies must be based on workplace practice and should provide evidence of the use of different skills in appropriate situations. They should describe actions…"***

The should all need to be replaced by must. The use of should is not appropriate in this context.

60.Do you have any suggestions for improvements to the multiple choice questions (MCQs)?

Check the yes option if you wish to give comment on the requirement for inclusion of MCQS, the requirement as an assessment method

(●) Yes

( ) No

61.Please detail your improvements to MCQs

The suggestion that MCQ's ***could*** be included in the overall assessment methodology and ***could*** be included in any of the domains is not acceptable.

Given the IET of technicians and the evidence of plagiarism an independent MCQ taken under exam conditions at an independent assessment centre ***must*** be included as part of any revised NCF. It ***must*** encompass ***all*** competencies (and ***not*** just any, as suggested in the NCF).

Section 5.9 - Support

This section outlines the support that programmer/course providers should provide to pharmacy technicians undertaking their programme/course provision

62.Do you agree with the Support section of the framework?

This question is related to section 5.9 - Support

- Yes
- No
- Don't know

63.Please give details of what you disagree with

The best support that a technician could get would be having a senior clinical pharmacist or a GP as a supervisor. From this starting point, the other relevant support points would ensue.

What we find astonishing in this NCF is that whilst support is mandated for the trainee there in no mention of the overarching obligations of a trainee.

For example, a trainee must “work with the supervisor” to identify competencies that need further development. For a work-based training programme to actually be effective they need to address the obligations of both trainee and their supporting trainers/supervisors.

Section 5 Application of the Framework Recommendations :

- The application criteria need revision to reflect the clinical nature of the proposed roles.
- The management plan and learning agreements need to acknowledge the need that trainees need mentoring.
- Clinical knowledge is the underpinning foundation for these roles and must be taught, learnt and examined.
- The 18 month timeframe needs to be considered in light of the ambition nature of the proposed NCF.

Overall Framework Feedback

64.Do you have any comments to make on the overall document?

Check the yes option to give feedback on the glossary of terms, language in the document, the ability of the framework structure to facilitate the mapping of courses/programmes, any organisational barriers, the robustness of the assessment strategy, the referencing in the document

(●) Yes

( ) No

65.Please detail your improvements to the overall document

We note that there are only 8 references listed which have been used to develop this NCF.

Notable omissions are :

1/ The PCPA and RCGP guide to pharmacists working in GP practices

2/ The CPPE training framework for pharmacists in GP practices

3/ The PCPA role specifications for Band 5 / Band 6 primary care technicians

This clearly shows that the NCF has been developed as a standalone piece without proper context and without due thought of how technicians can work to support pharmacists to support GPs in ensuring the most appropriate and safe care for patients.

Pharmacy technicians would have been better served if this NCF recognised that technicians will be working as ***part*** of a multidisciplinary team where everyone works symbiotically to ensure the very best patient care.

References : (in addition to those within the "National Competency Framework" (all accessed 22.07.2020)

1/
http://www.doncasterlmc.co.uk/Guide%20for%20GPs%20employing%20pharmacy%20staff.pdf

2/
https://www.uea.ac.uk/documents/899297/15294873/Identifying+The+Role+Of+Pharmacy+Technicians+In+The+UK/d6d60e7b-f527-481a-8f16-9f3f04037b6c

3/
https://www.hcpc-uk.org/globalassets/meetings-attachments3/council-meeting/2003/march/council_meeting_20030307_enclosure04/

4/
https://www.pharmacyregulation.org/sites/default/files/document/gphc-2019-survey-pharmacy-professionals-main-report-2019.pdf

5/
https://www.the-pda.org/wp-content/uploads/FINAL-PT-Report-28-02-19.pdf

6/
https://www.skillsforhealth.org.uk/news/latest-news/item/742-new-qualification-for-pharmacy-technicians-project-update?highlight=WyJwaGFybWFjeSJd

7/
https://www.aptuk.org/foundation-pharmacy-framework

8/
https://www.aptuk.org/static/pdf/1d828536f790c7b842907dc23096d62a.pdf

9/
https://www.cityandguilds.com/-/media/productdocuments/health_and_social_care/pharmacy_services/5355/5355_level_3/centre_documents/5355-03_l3_nvq_diploma_pharmacy_service_skills_qhb_v3-2-pdf.ashx

10/
https://www.hee.nhs.uk/our-work/pharmacy/pharmacy-training

11/
https://www.cppe.ac.uk/wizard/files/pharmacy-technician-pilot-offer-feb20.pdf

12/
https://pcpa.org.uk/job-descriptions.html

13/
https://www.pharmacyregulation.org/education/pharmacy-technician

14/
https://www.aptuk.org/static/pdf/1ce9132545b2e5df22cbf8c2bf2c1967.pdf

15/
https://bmjopen.bmj.com/content/bmjopen/6/2/e008751.full.pdf

16/
https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1365-2648.2012.05971.x

17/
https://www.england.nhs.uk/wp-content/uploads/2018/10/clinical-pharmacists-in-gp-phase-2-guidance-applicants.pdf

18/
https://webarchive.nationalarchives.gov.uk/20120503224921/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4137276.pdf

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