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Pharmacy technicians: an assessment of the current UK landscape, and proposals to develop community pharmacist and pharmacy technician roles and skill mix to meet the needs of the public

Chapter 7

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7 Aligning the interests of pharmacists and pharmacy technicians

7.1 The success of skill mix in hospital pharmacy

In recent years, the government has expended a considerable amount of energy on attempting to distribute the tasks of pharmacists to pharmacy technicians in the community pharmacy sector. With the government seeking to deliver more services for less investment, employers – and particularly among the large corporate multiples – have sought to reduce their costs in order to shore up their profits. However, those driving this process have failed to learn the important lessons of the successful development of skill mix in the hospital sector, which has been highly beneficial for pharmacists, pharmacy technicians and patients.

In the late 1970s and 1980s, hospital pharmacy leaders created a vision for the role of hospital pharmacists. This ambitious vision involved hospital pharmacists in much more clinical and patient-facing roles which were much more integrated with the wider healthcare team. They envisaged that in the future, hospital pharmacists would be predominantly based on wards, because this was where they would have face to face contact with patients - which would allow them to develop clinical relationships and make much greater use of their clinical skills. To achieve this, a mechanism had to be found to release them from roles which, for the majority, had hitherto been predominantly based in the dispensary and at some considerable distance from patients.

Once an attractive vision for hospital pharmacists was determined by its leaders, a plan was established to turn this vision into reality. Central to the plan was the development of a skills and salary escalator for hospital pharmacists. Higher levels of training and qualification and greater responsibility for pharmacists led to more clinical roles out on wards, improved status and remuneration. The range of new patient-facing, ward-based, clinically-orientated services being

delivered by pharmacists became highly valued by other members of the healthcare team and were highly beneficial to patients. In essence, a structured career framework was created for hospital pharmacists. It was clear that at the outset, some of the tasks that had previously been the domain of pharmacists - predominantly dispensary-based activities - would need to be delegated to pharmacy technicians. The reliance upon effective skill mix in pharmacy had well and truly arrived.

It became apparent that the prospect of success for the entire process would also benefit from the introduction of a skills and salary escalator for hospital pharmacy technicians. Consequently, a banded, structured career framework for hospital pharmacy technicians was also created. The success of this model of skill mix became directly linked to the possibility of new roles and responsibilities for both hospital pharmacists and hospital pharmacy technicians. The delegation of tasks by pharmacists to hospital pharmacy technicians created a route to clinical pharmacy practice, improved professional fulfilment and increased the status of both of these groups. In that sense, the interests of pharmacists and pharmacy technicians were aligned, to the benefit of both groups and the public. This was the basis of the successful model seen in hospital pharmacy today.

Thirty years later, senior hospital pharmacists are working at the cutting edge of clinical practice as specialists and consultants. In many instances, they are heavily relied upon by patients and senior medics for their expertise around medicines and pharmacotherapy. Hospital pharmacists are working within a banded career and remuneration structure, which enables them to plan their career trajectory and higher qualifications from an early point in their employment. Pharmacy technicians also enjoy a structured career framework, allowing those at the senior levels of the structure, with degree-level qualifications or similar, to take on much more responsibility. In many instances, they enjoy salaries that exceed those of their junior pharmacist colleagues.

There is a very substantial difference between the situation in hospital pharmacy and that in community pharmacy, insofar as it relates to pharmacy technicians. Perhaps it is unsurprising, given the genesis of hospital pharmacy technician practice, that the majority of the members of the APTUK and its Board of Officers come from a hospital pharmacy background. As several sections of this report also describe, pharmacy technicians from the hospital pharmacy setting generally have a much better-developed understanding of professionalism and accountability than their community pharmacy counterparts.

Schafheutle et al concluded in 2017 that *"Rather than differentiating a PT qualification, which is currently generalist, into one which differs between sectors, it may be more valuable to look to hospital pharmacy for skill mix models which could be implemented in community to support and effect these changes."* [1] The skill mix model must be defined before the initial education and training - and the pharmacy technician qualification - can be developed.

7.2 The lessons from skill mix in hospital practice have not been learned by policymakers

Civil servants, policy makers and even some amongst the leadership of the pharmacy profession have not applied the learning from the hospital pharmacy experience to the development of skill mix in the community pharmacy setting. Many examples exist where the narrative of success relating to the development of pharmacy technicians' roles in the hospital setting (which employs the minority of pharmacy technicians) is simply and in an unqualified way transposed onto discussions about the future of skill mix in the community pharmacy setting (where the majority of pharmacy technicians are employed). Exemplars of widespread success in the hospital or primary care setting and also in niche, often unique roles, are used to argue for the delegation of tasks by pharmacists to pharmacy technicians in community pharmacy - where very few such exemplars exist.

Crucially, one fundamental difference between hospital and community pharmacy practice has not been properly taken into account by those seeking to allow pharmacy technicians to supervise a pharmacy where the pharmacist may be absent. Hospital pharmacists leave the dispensary and go out on the wards to enjoy their patient-facing clinical roles because that is where the patients in hospitals are to be found. In community pharmacies, pharmacists do not have to leave the pharmacy to go to find patients because in the community pharmacy setting, the patients not only present themselves at the pharmacy, but they expect a pharmacist to be available to them upon arrival. Consequently, clinical relationships are developed with patients within the community pharmacy. This is a very important reason as to why such resistance to the notion of operating a community pharmacy in the absence of a pharmacist exists among community pharmacists. Perhaps this lack of understanding has occurred because those who most strongly support the development of pharmacy technician roles in community pharmacy, and advocate the absence of pharmacists, are either pharmacy leaders who come from a hospital pharmacy background and do not have any substantial experience of working in community pharmacy or an understanding of its dynamics, or even those who are currently, or at some stage in their careers were, pharmacy technicians working in hospital pharmacy themselves.

The approach taken - particularly by civil servants - to the development of skill mix in community pharmacy does not bear any resemblance to the approach which led to its successful development in the hospital sector. There is no professionally-led plan, developed in detail and through the engagement with coalface practitioners, which sees community pharmacists developing a structured career framework linked to a skills and salary escalator. No hierarchy has been created of new and professionally-rewarding roles for pharmacists delivered in the community pharmacy. No discernible, unifying, strategic vision for the future of community pharmacy has been determined.

What prevails instead is a top-down approach, where pharmacists are being asked by civil servants to contemplate a future in which they will no longer be required in a community pharmacy, since they will be required to delegate tasks to pharmacy technicians. They may be required to supervise the whole process and the pharmacy staff remotely, in all probability as the sole pharmacist, and for which they will still be statutorily responsible and accountable for the safe and effective operation of the pharmacy in accordance with the Responsible Pharmacist regulations. All of this is to be considered by pharmacists in the context of known employer behaviour in so far as it relates to cost-cutting and the reduction of staffing levels - which for some employers may be to the furthest extent permissible in law, contract or regulatory standards.

In the current government programme of Rebalancing Medicines Legislation and Pharmacy Regulation, the interests of pharmacists and pharmacy technicians have not been aligned and the skill mix proposal has not been linked to fulfilling, rewarding career prospects or a structured career framework with associated skills and salary escalator for both groups. It has, instead, been linked to the prospect of a diminution of employment prospects for pharmacists, concerns over personal exposure to liability and the forced acceptance of significantly greater responsibilities for pharmacy technicians, for which they continue to receive comparatively meagre salaries.

Conscientious pharmacy technicians who value the future prospects of their occupation and the impact on patients ought to be dissatisfied with the approach. It is perhaps the lack of community pharmacy experience in the APTUK that has led to the lack of a satisfactory strategy and the acceptance of a future which is not in pharmacy technicians' long-term interests, but which is being championed enthusiastically by civil servants and some employers looking to cut costs.

Far from resulting in a positive and welcome force for change, as was seen in the hospital pharmacy setting, skill mix in community pharmacy has become linked to the prospect of remote

supervision. Developments are viewed with suspicion and are seen as a threat to pharmacists and patient safety.

Although the government announced the possibility of operating a pharmacy in the absence of a pharmacist in 2006, it has still not secured the support of pharmacists and is unlikely to do so whilst the current approach persists. It is also unsurprising that community pharmacists' attitudes to skill mix are currently not at all positive.

A number of studies have surveyed the current attitudes of both pharmacists and pharmacy technicians relating to the delegation of tasks by the former to the latter. These identify that there remains a significant hurdle based on a lack of trust. This lack of trust has its roots in pharmacists' lack of confidence in the training, competency and professional credentials of pharmacy technicians, the misuse of particular skill mix models by some employers to reduce costs and the wider political/professional skill mix agenda which is being enthusiastically promoted by civil servants.

Recent GPhC-commissioned research has identified the need for pharmacists to be able to have trust and confidence in pharmacy technicians:

- *"As pharmacists' roles become increasingly clinical and new services are being developed, pharmacy technicians play an increasingly important part in the provision of pharmacy services throughout Great Britain. The public, patients, colleagues (particularly pharmacists) and employers thus need to be assured that pharmacy technicians are qualified to the required standards, and meet these standards of conduct, ethics and performance, throughout their careers."* (2014) [2]
- *"Accountabilities of pharmacists and PTs needed to be more clearly defined."* (2015) [3]

- *"To enable pharmacists to become increasingly patient-centered, clinical professionals, they need to work with suitably trained and competent support staff; pharmacy technicians (PTs) may be the most appropriate to take on additional roles and responsibilities. However, clarity on PT roles, particularly in community pharmacy, is lacking, and pharmacists may be reluctant to delegate due to concerns over PTs' competence." (2017)* [1]

The researchers involved in the studies quoted above recognised the importance of pharmacists being assured that pharmacy technicians were appropriately qualified. The GPhC commissioned three separate studies exploring the views of various stakeholders on pharmacy technician education and training. [2] [3] [4] The stakeholders included representatives of education providers and authorities, the APTUK, pharmacy technicians and community pharmacy business owners. Unfortunately, the GPhC did not ask the researchers to seek the views of employee and locum pharmacists as interested groups, through their representatives, to understand whether the current training standards met modern practice requirements. As with the approach from the Rebalancing Medicines Legislation and Pharmacy Regulation programme board, a synthesis of the collective views of front-line employee and locum pharmacists was excluded from the discussion.

7.3 The views of pharmacists and pharmacy technicians

A recent study found that both pharmacists and pharmacy technicians (from both the community and hospital settings) believe that pharmacy technicians can perform certain limited activities without a pharmacist's supervision that they cannot perform unsupervised at present. Respondents also agreed that since pharmacy technicians are now registered with the regulator, they should accept greater accountability for the tasks they perform, though many did not believe that the pharmacy technician's role had changed since GPhC registration was introduced. [5] [6]

Respondents were asked to assume that support staff (defined as those with an NVQ level 2 or 3 qualification, since not all pharmacies work with a pharmacy technician) were suitably trained and competent. They were asked to evaluate the safety of support staff conducting a range of named activities in community pharmacy whilst the pharmacist was not physically present on the premises for up to 2 hours, but was contactable to advise and intervene. The researchers then graded the activities as 'safe', 'borderline' or 'unsafe'.

The seven 'safe' tasks all required limited skill, knowledge and responsibility:

- Take in prescriptions
- Sell General Sales List (GSL) medicines
- Sign for deliveries of medicines (not Controlled Drugs (CDs))
- Assemble (without labelling) prescriptions (not CDs)
- Label prescription items (not CDs)
- Signposting to other services
- Provide healthy living advice.

Of these, community pharmacists did not classify 'labelling of prescription items' as safe – and were on the verge of classifying 'assemble (without labelling) prescriptions (not CDs)' as borderline. Community pharmacy technicians perceived the risks associated with the 'safe' activities to be lower than did the other groups.

Nine 'borderline' activities were identified. For each activity, community pharmacists – whose input is perhaps the most important and based on the most relevant contextualised experience of the four groups surveyed (pharmacists and pharmacy technicians working in either the community or hospital setting) – disagreed that it could be safely carried out in their absence.

Another six activities were thought to be 'unsafe' for support staff to perform:

- Provide a minor ailments service
- Provide medicines under a patient group direction
- Give advice about prescription only medicines
- Give clinical advice to patients
- Provide the New Medicine Service (NMS)
- Conduct Medicines Use Reviews (MURs).

This study identified a number of factors which affected pharmacists' confidence in pharmacy technicians' abilities to perform certain roles. A key point was that familiarity with the team reduced the perception of risk; more permanently-based and experienced pharmacists were less cautious, as were those accustomed to working with a larger support team. Locum and relief pharmacists were more cautious.

Any successful rebalancing of the roles of community pharmacists and pharmacy technicians through labour substitution would be heavily reliant upon the support and participation of pharmacists, in terms of delegating the tasks in the first place, and pharmacy technicians, in terms of taking upon themselves the additional responsibilities. Consequently, it would be important to explore further the views of both groups of practitioners.

7.4 Patient Group Directions (PGDs) as a possible role for pharmacy technicians?

In 2013, in response to a National Institute for Health and Care Excellence (NICE) consultation on the use and application of patient group directions (PGDs), the Guild of Healthcare Pharmacists suggested that pharmacy technicians should be added to the list of healthcare professionals that should be allowed to operate PGDs. [7]

If this suggestion were to be implemented, it would probably apply across all pharmacy sectors (hospital, primary care and community), with potentially far-reaching implications for patient care. The PDA conducted a survey of its members in 2013, to determine pharmacists' views on this proposal.

7.4.1 What is a PGD?

PGDs are written instructions for the supply or administration of medicines to groups of patients, who may not be individually identified before presentation for treatment. The MHRA states: *"The supply and administration of medicines under PGDs should be reserved for those limited situations where this offers an advantage for patient care without compromising patient safety, and where it is consistent with appropriate professional relationships and accountability."* [8]

PGDs should be drawn up by a multi-disciplinary group involving a doctor, a pharmacist and a representative of any professional group expected to supply medicines under the PGD. The MHRA also states*: "A senior person in each profession should be designated with the responsibility to ensure that only fully competent, qualified and trained professionals operate within directions."* [8]

The qualified healthcare professionals who are currently allowed to supply or administer medicines under a PGD are: pharmacists, nurses, midwives, health visitors, optometrists, chiropodists, podiatrists, radiographers, orthoptists, physiotherapists, ambulance paramedics, dietitians, occupational therapists, speech and language therapists, prosthetists, orthoptists, dental hygienists and dental therapists. They can only do so as named individuals. [9]

7.4.2 The views of pharmacists

Only 4.5% of pharmacists responding to the PDA survey - of over 1,300 of its members - agreed with the proposal. [10] Many respondents expressed concerns with the proposal and were anxious about patient safety and pharmacy technicians' lack of knowledge and accountability. Community pharmacists were particularly opposed to the concept, with less than 2% in favour.

PGDs are designed to be administered by those who are able to work autonomously and do not require supervision. Many pharmacists were concerned that pharmacy technicians do not meet the rigorous standards of qualification, regulation and accountability required of a healthcare profession. These standards are necessary to protect the public; if they are not met, patient safety is put at risk.

7.4.2.1 Concerns over safety

Safety was a very substantial concern, with 80% of all respondents saying that pharmacy technicians would be unable to operate any and all PGDs "as safely and effectively as pharmacists", while a further 8% were "neutral" on the issue.

7.4.2.2 Lack of knowledge

Also high on pharmacists' list of concerns was pharmacy technicians' lack of knowledge, with nearly three quarters concerned that this would hinder their delivery of PGDs.

"Patient safety is paramount. From what I have witnessed of NVQ training it does not touch on the required level of clinical knowledge", said one.

Another, who claimed to be the lead pharmacist for PGDs at an NHS foundation trust, said that pharmacy technicians' *"lack of underpinning clinical knowledge and skills would make this an unsafe practice".*

A number of pharmacists pointed out that length of service was no guarantee of standards. One pharmacist commented *"Some of them have been in the job for 10 years or more and still struggle with their current roles such as dispensing. A lot of them are not even great at WWHAM, let alone PGDs."*
N.B. WWHAM stands for "Who is the patient? What are the symptoms? How long has the patient had the symptoms? Action taken already? Medicines – is the patient taking any other medication?". It is a mnemonic used commonly by community pharmacy staff in the UK to help ensure patients requesting medicines from the pharmacy counter are asked the appropriate questions. [11]

Another pharmacist warned that pharmacy technicians *"will 'dumb down' PGDs as counter assistants have dumbed down the sale of P medicines."*

7.4.2.3 Lack of accountability

In the survey, pharmacy technicians' perceived lack of accountability was cited as a concern by 58% of pharmacists in community practice and 43% of those working in NHS hospitals. Many suggested that if pharmacy technicians were to operate PGDs, they should be held liable for their actions in this area. Many respondents thought that pharmacy technicians would be unaccustomed to assuming such responsibility. Some community pharmacists suggested that the employer should be liable, rather than the pharmacist. Locums were particularly concerned about accountability, given that it would be difficult for them to be sure of an individual's competence.

Comments included:

- *"In my experience pharmacy technicians are very poor at understanding professional responsibility."*
- *"I feel that if they were to offer PGDs they would throw all responsibility to the pharmacist supervising the activity and take no responsibility themselves."*

Without consulting publicly or widely with front-line pharmacists or pharmacy technicians for their views, in 2016 the "Murray review" of Community Pharmacy Clinical Services, commissioned by the Chief Pharmaceutical Officer in England, made the following recommendation: *"Regulations should be amended to allow registered pharmacy technicians to work under Patient Group Directions to allow better use of skill-mix in delivering clinical pharmacy services."* [12] The review was commissioned in April 2016 and had a broad scope, including making recommendations as to what clinical services should be provided by community pharmacy in the future and how they should be commissioned. [13] It was completed and published just eight months later in December 2016. The reviewer received advice from an advisory group, the composition of which is unclear and was not stated in the report (though the APTUK's website indicate that it was represented). [14] Unfortunately, this provides another example of top-down policy determination which may not have involved the input of clinical practitioners and/or their representatives as recommended in the Francis inquiries in to the Mid Staffordshire NHS Foundation Trust (this was discussed in relation to the Rebalancing Medicines Legislation and Pharmacy Regulation programme board in Section 5).

7.5 The views of pharmacy technicians

A survey of pharmacy technicians showed that 57% of community pharmacy technicians are in favour of adopting an extended role, with 25% being against. [15] The concept is much more

popular among those in the hospital sector, with 80% of hospital pharmacy technicians saying they would be in favour and only 13% being against. Reasons for being against an expanded role included lack of remuneration, workload and training issues (see Table 1).

Table 1 - Reasons that pharmacy technicians are against adopting an extended role

Reason	% of respondents identifying
Lack of commensurate remuneration	36
Excessive workload	26
Don't know / need to look in more detail	14
Lack of training	12
Not happy / don't agree generally	10
Other	9
Concerns over increase in responsibility	7
Responsibility should lie with pharmacist / they have been to university	5
Concerns over increase in 'personal liability'	5

Note: It was possible for respondents to identify more than one reason.

When asked about taking on "more demanding roles and responsibilities", the proportion in favour dropped to 50% for those in community pharmacy practice and 60% for those in hospital pharmacy practice. Reasons for being against taking on more demanding roles and responsibilities included comfort within current roles, workload and already being too busy (see Table 2).

Table 2 – Pharmacy technicians' reasons for not considering taking on more demanding roles and responsibilities

Reason	% of respondents identifying
Current workload sufficient	28
Depends on the role / what it entails	22
Already very busy / no capacity to do more	19
Constraints around working environments	8
Age – too old/due to retire	8
Too much responsibility	8
Other	8

Among those pharmacy technicians who would consider taking on more demanding roles and responsibilities, there were a number of provisos. The most important of these was that they wanted more training and qualifications, followed by higher pay (see Table 3). Just 1% in community pharmacy and 7% in hospital were prepared to take on new roles in the current environment without any changes. 45% of community pharmacy technicians required pharmacists to supervise them more closely if they were to take on more demanding roles and half required assurances that it would be the pharmacist - and not the pharmacy technician - that would be held responsible and liable in the event of an error. These percentages were markedly different for pharmacy technicians working in the hospital pharmacy setting.

Table 3 - Changes required before pharmacy technicians would consider taking on more demanding roles and responsibilities

Change required	% agree (community)	% agree (hospital)
More training and qualifications	80	90
Paid more	77	76
Assurance that pharmacist, not pharmacy technician, would be responsible and held liable	50	28
Would be more closely supervised by pharmacist	45	38
Improved or stricter processes in the pharmacy and/or dispensary	34	62
Other	4	3
Nothing, happy to take on more demanding roles and responsibilities immediately	1	7

Having declared that they would consider taking on more demanding roles and responsibilities, the pharmacy technicians surveyed appeared unclear about exactly what roles they might consider. Whilst a wide range of potential services was selected, none of the services proved particularly popular (see Table 4).

Table 4 - Additional tasks that pharmacy technicians would consider taking on

Additional task	%
None / nothing	28
Don't know	9
Patient centred (e.g. offer advice / patient interaction	15

Additional task	%
More services / service provision	9
Prescription checks	8
Help the pharmacist more / when pharmacist not available	8
Smoking cessation/stop smoking clinics	7
Patient counselling	6
MURs / medicines management / patient medicine review	9
Accredited checking technician's course	5
Healthy living/wellness advice / checks	4
Blood pressure	4
Clinical training	3
Diabetes	3
Prescription dispensing	3
Flu vaccinations	3
Controlled drugs	2

A significant number of pharmacy technicians explained that they would consider leaving the register altogether if they were expected to take on more demanding roles and responsibilities. Only half would be "very likely", while 29% would be "quite likely" to remain registered. The survey found that 16% would be "quite" or "very" unlikely to remain on the register.

7.6 The impact of pharmacy technician support on pharmacist workload [16]

There is little evidence to suggest that under current arrangements, granting pharmacy technicians additional roles in community pharmacy would free up pharmacists' time in a way which would allow it to be usefully spent with patients.

A study was undertaken in 1995 to assess the impact of skilled dispensary help on pharmacists' work activities by comparing two similar independent community pharmacies (with respect to prescription volume) - one with and one without a pharmacy technician. The study showed that the pharmacy technician released one hour of the pharmacist's time each day. However, this time was not continuous or predictable and this meant that the pharmacist was not able to dedicate it to patients in any structured or meaningful way. [16] [17]

Preliminary findings from 2002 of a study conducted by Jones and Rutter suggest that the introduction of accuracy checking technicians reduces the time pharmacists spend dispensing. This, in turn, allows them to spend more time in direct contact with patients. [18] However, if pharmacists could be given additional time to spend with patients through the development of pharmacy technician roles, in order for the benefit to be sustainable it may have to be done in such a way that the additional time with patients was secured by law or through the NHS pharmacy contract. Otherwise, the temptation to reduce costs in order to increase profit may be too great for some employers and no meaningful patient benefit would be secured.

The authors of a study commissioned for the Department of Health suggested that implementing different models of skill mix is more feasible in larger organisations where business activities such as purchasing, for example, operate as separate departments and are performed by specialists. In contrast, it is more difficult to implement different models of skill mix in smaller organisations where pharmacy staff have to undertake a broader range of tasks. Linked to organisational size, the authors assert, is financial viability, where it is likely that the larger organisations are better resourced, in both financial and human terms, to implement skill mix models. [16] This may not apply to large corporate multiple pharmacies, whose patient-facing activities are conducted across many different premises and where the separate departments referred to above are managed and operated at a head office level.

Studies in the hospital setting that have involved pharmacy technicians performing pharmacists' duties mainly considered defined tasks, such as obtaining drug histories, drug distribution, assessing patients' drugs, preparing discharge medications and record keeping. [19] The majority of the reported work on substitution of pharmacists with pharmacy technicians has been undertaken in the hospital setting, with only a small number of studies undertaken in community pharmacy. There is limited evidence on skill mix in community pharmacy and the difficulties in comparing between organisations are apparent from the small amount of evidence that is available. For example, one of the difficulties is that the nomenclature used to describe support staff varies. These studies were mainly conducted in the USA, further complicating comparisons.

According to a 2011 research study conducted for the Centre for Workforce Intelligence:
"there are a number of concerns regarding pharmacy technicians, including whether they have sufficient training in ethical decision-making to substitute for pharmacists and whether they are equipped with the knowledge and autonomy to safely substitute for pharmacists". [19]

This review also concluded that there is a lack of clear evidence to show that the skill mix models examined are cost effective. It recommended further research into skill mix and the training needs of pharmacy technicians.

7.7 Conclusions

1. The successful model of developing pharmacy skill mix in the hospital sector occurred because its genesis emerged from pharmacists and because it was led by the profession. It was built upon a desire to create new, ambitious and professionally-fulfilling roles for pharmacists that were of benefit to patients. The approach aligned the interests of pharmacy technicians and pharmacists in a way that involved delegation and required effective skill mix and clear role definitions as a prerequisite to success. The process was

seen as a success by both pharmacists and pharmacy technicians. First came the vision for pharmacy and then came a structured career framework, which was linked to a skills and salary escalator. The structured career framework allowed specialisation and higher levels of practice for both pharmacists and pharmacy technicians; this continues to flourish today.

2. The approach being taken to skill mix in the community pharmacy setting is not being led by the profession – and of particular importance - pharmacists working at the coalface. Neither is it in support of an agreed ambitious vision, nor linked to a structured career framework. It does not align the interests of pharmacists, pharmacy technicians and patients. It does not require investment in the training of pharmacy technicians nor the support of high standards of training. Instead, it is a top-down approach being taken by civil servants and is strongly linked to the prospect of operating a pharmacy in the absence of a pharmacist, which is perceived as a threat by pharmacists and many pharmacy technicians alike.

3. The development of hospital pharmacy practice in the 1980s was designed to ensure pharmacists' skills could be put to best use, by giving them greater contact with patients - out on hospital wards. The roles of pharmacists were developed first and the roles of pharmacy technicians were developed later to support those of pharmacists. By contrast, the proposals currently being considered by the Rebalancing Medicines Legislation and Pharmacy Regulation programme board could see pharmacists taken away from patients – such that they will not be present in the community pharmacy. The proposals from the programme board's supervision working group could mean that community pharmacies

may instead be supervised by a pharmacy technician, with the pharmacist absent from the premises. [20]

4. The approach described above has led to a lack of trust in the process of ensuring appropriate skill mix generally and the direction of the current debate around pharmacy supervision being undertaken by the Rebalancing Medicines Legislation and Pharmacy Regulation programme board, compounded by a lack of trust in pharmacy technicians' abilities. Pharmacists, faced with the requirement to delegate tasks, are anxious about patient safety and express concerns about the lack of knowledge and accountability of pharmacy technicians, and about the government's apparent attempt to inappropriately professionalize pharmacy technicians, seemingly at any cost. Since there is no alignment of interests between pharmacists and pharmacy technicians, there is no incentive for pharmacists to delegate tasks and what delegation exists is piecemeal, resulting in very limited benefits in terms of additional pharmacist availability. This lack of alignment also results in pharmacy technicians being reluctant to take on additional responsibilities. Pharmacy technicians have indicated that before they would take on any further roles, they would need to receive more training and higher pay. Those working in community pharmacy, in particular, feel that they would require an undertaking that any mistakes would be the responsibility of the pharmacist and not of the pharmacy technician. This view further undermines the current civil service parlance that community pharmacy technicians generally should be viewed and relied upon as healthcare professionals in their own right.

7.8 Recommendations

1. Pharmacists, as the pharmacy profession, must collectively agree a unified vision for the future of community pharmacy and then determine a plan of how to turn that vision into reality. This should be led by the interests of patients, including ensuring that patient contact with and access to pharmacists' clinical expertise is maintained and enhanced.

2. Once the vision for future of the profession has been agreed, as part of that vision and in the process of bringing it to fruition, a symbiotic, complementary skill mix of pharmacists and pharmacy technicians must be developed in community pharmacy. This must be led by the profession and not the civil service.

3. The interests of pharmacists, pharmacy technicians and patients must be aligned in order to develop a successful skill mix model.

4. A successful exercise to achieve effective skill mix must provide for both pharmacists and pharmacy technicians to work at a multitude of levels in a well-defined career hierarchy and enable individual practitioners to understand and manage their career goal objectives from an early point in their careers.

5. A structured career framework, which relies upon a skills and salary escalator, should be developed by the profession for both pharmacists and pharmacy technicians, aligned to the development of new, clearly-defined, professional, clinical and technical roles in the community pharmacy setting.

6. The differences in pharmacy technicians coming from the community and hospital pharmacy settings must be appreciated and factored into any future policy work on pharmacy skill mix.

7. In order to reflect the substantial differences between pharmacy technicians that trained and continued to work in community pharmacy and those that trained in hospital pharmacy, the GPhC should agree a process to annotate the register of pharmacy technicians to reflect the sectoral differences.

8. As part of a wholesale re-engineering of community pharmacy practice, research should be undertaken to evaluate the feasibility and impact on patient safety and care of having a pharmacy technician (trained appropriately to the standards recommended elsewhere in this report) in every pharmacy alongside a pharmacist, throughout its operating hours. This could form part of a new model of working in community pharmacy, such as that outlined in the PDA's Wider than Medicines proposals. [21]

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