

9 Overall conclusions

This Chapter contains overarching, high-level conclusions. More detailed conclusions are made at the end of each of the Chapters 1 to 8; these should be read separately.

9.1 The differences between pharmacy technicians in the hospital and community pharmacy settings

With the notable exception of the relatively small proportion of pharmacy technicians now working in primary care pharmacy (around 6% of pharmacy technicians - see Appendix B), broadly speaking, pharmacy technicians in the UK can be delineated into two significant sectoral groups; those working in hospital and those working in community pharmacy. [1] The differences between these two groups are significant. Whilst the minority (those working in hospital pharmacy – 21.2% to 39% depending on the reference source) have enjoyed a professional development and career framework for several decades, the majority (those in the community setting – 53% to 67.4% depending on the reference source – see Appendix B) have suffered from long-term underinvestment in terms of training, remuneration and lack of a structured career framework. [1] [2] For these and other reasons, pharmacy technicians in the community pharmacy setting are not yet ready to take on more clinically-orientated responsibilities, because patient safety cannot be guaranteed under the existing regulatory and professional frameworks. Although there are good examples of highly-qualified individuals delivering cutting edge practice to high standards in the hospital sector and in a small number of cases in the community pharmacy sector, most pharmacy technicians working in the community are neither suitably qualified nor sufficiently well-regulated to enable the group to safely and effectively deliver more clinically-orientated roles, or roles with higher levels of responsibility than at present.

9.2 A lack of regulatory traction

Public protection, particularly in healthcare, is maintained in part by the fact that individuals making decisions affecting the public's health and wellbeing are members of strictly-regulated professions. Members of a profession must meet high standards of qualification, practice and continuing education. Standards are maintained by strong professional leadership and effective regulation. Regulatory traction over professionals is achieved through a range of sanctions, but the most powerful is the ultimate sanction of being 'struck off', leading to the loss of professional status and earning potential.

Despite compulsory registration since 2011, pharmacy technicians as a collective group do not meet commonly-accepted definitions of a healthcare profession, and many pharmacy technicians do not view themselves as professionals. They have a leadership body (APTUK) with only 1,380 members (6% or less of the total UK workforce). [3] The membership of the APTUK is disproportionately composed of hospital-based pharmacy technicians and the organisation has minimal representation from community pharmacy-based technicians on its Board of Officers (only 1 out of 14 appointed officers worked in community pharmacy as at November 2017). Poor pay and low levels of recognition for pharmacy technicians mean that their regulator lacks the necessary traction to provide public protection, and it is doubtful that it could gain the necessary traction whilst such conditions persist. There is further cause for concern about the effectiveness of healthcare regulation of pharmacy technicians since those subject to fitness to practise proceedings routinely demonstrate that they lack the motivation to even attend a regulatory hearing into their own alleged misconduct.

Pharmacy technicians in the hospital sector are remunerated according to national NHS Agenda for Change pay scales that recognise their qualifications and experience. Despite this, their starting pay is still way below that of other healthcare technicians and only equivalent to that of

dental nurses. The salaries of pharmacy technicians working in the community are often much lower than those of hospital pharmacy technicians, with levels comparable to those of general customer service occupations such as retail cashier, checkout operator and travel agent. There is no nationally-recognised pay scale for community pharmacy technicians.

Poor salaries and conditions suggest that pharmacy technicians are not regarded as professionals by employers - especially in the community setting - or by society generally. The result is that they have less to lose from regulatory sanctions than any other healthcare-related technicians. The traction required by a regulator to enable it to act effectively and protect the public interest is very limited when dealing with pharmacy technicians from the community sector (53% to 67.4% of the entire register of pharmacy technicians – see Appendix B). [1] [2] It could therefore be argued that public protection is compromised.

A legal case against a pharmacy technician in the US, employed by Walgreens, demonstrates how public attitudes could quickly turn against pharmacy technicians in the UK if they failed to meet higher standards. [4] The US-based multiple, which merged with Boots in 2014, was ordered to pay nearly \$26m in damages after one of its pharmacy technicians made a dispensing error.

Walgreens has been accused of adopting a “fast food” culture to enhance profits in its pharmacies. A lawyer involved in a number of dispensing error lawsuits in the US said: *“In fact, a lot of the people working in the pharmacy have about the same level of training as someone that would be working in fast food... Forgetting to put your fries in the bag isn’t going to lead to any harm, but obviously we’re dealing with something much more serious with medicine.”* [4]

A case involving a Lloydspharmacy staff member illustrates the risks inherent in using inadequately trained staff to carry out healthcare roles. [5] The same lancet was used to draw

blood from a number of patients being tested for diabetes at its Rhyl branch. This graphically illustrated a fundamental lack of understanding of basic clinical practice.

It has been recognised that the routinisation / “McDonaldisation” of work in large bureaucratic organisations, such as the large corporate multiples operating in community pharmacy, leads to reduced professional autonomy and may lead to deskilling of the workforce. [6] [7] Corporate businesses may see a profit benefit in keeping the costs of the pharmacist and pharmacy technician workforce as low as possible and either promoting, or allowing to continue, the perception that pharmacy technicians in the community sector are ready to take on new responsibilities. Yet, even the APTUK, a leadership body for pharmacy technicians, recognises that there is no clear role definition. [3] It is difficult to understand how new responsibilities can be given to pharmacy technicians without first clearly defining the role - unless that role is being promoted with a view to reducing the scope of pharmacists’ roles in order to reduce labour costs for employing organisations and ultimately for the government, irrespective of the risks to the public.

The lack of traction in the regulation of pharmacy technicians is clearly demonstrated by the fact that only 27% of pharmacy technicians called before a GPhC fitness to practise committee hearing actually attend, with many apparently attaching so little importance to their registration that they simply prefer to find another job. It may be easier and more convenient for such registrants to find other work – with the potential for higher pay and without responsibilities to patients – than to attend the hearing. In addition, the fact that only 23% of pharmacy technicians called before a hearing work in the community sector (compared to 87% of pharmacists called before a hearing) is surely cause for alarm. It suggests that regulation of community pharmacy technicians is suboptimal.

Patients should always expect to consult with a healthcare professional when important decisions are being made about their treatment, because only healthcare professionals are suitably placed to make complex decisions based on individual patient requirements. The public must be confident that the standards that healthcare professionals are continually required to meet enable them to safely assume such responsibility. If there is a failure, the public can fall back on professional regulation as a remedy. As outlined elsewhere in this report, the public can only enjoy a very limited reliance on the regulation of pharmacy technicians - a cause for considerable concern. Policy makers, insofar as they consider the rebalancing of roles and responsibilities between pharmacists and pharmacy technicians, are urged to proceed with great caution.

9.3 Acting professionally or being a professional: causing confusion through the incorrect use of terminology

The GPhC, the DoH and others have started to refer to pharmacy technicians as professionals. Having used various objective measures to inform its view, the PDA believes that this is inappropriate. The use of the word 'professional' as an adjective (being professional) is altogether different to its use as a noun (being *a* professional) and the word carries different meanings in each case.

Definitions of the noun "professional" found in English dictionaries, in sociological literature and elsewhere, and from the UKIPG and the HCPC, indicate that pharmacy technicians have not achieved professional status. An exploration of the level of training possessed by the group, the genesis of the group's development and registration with the GPhC, the group's approach to attending fitness to practise hearings, the inability of the regulator to gain traction through sanctions for misconduct (due to the relatively low salaries paid to pharmacy technicians) and the differences between pharmacy technicians and pharmacists (see Appendix B) are worrying factors. These, coupled with a lack of a properly representative body for pharmacy technicians, are among

the factors which demonstrate that reference to pharmacy technicians as professionals not only lacks justification, but has the potential to mislead the public about the extent to which the group's capabilities could be relied upon and ultimately poses a risk to patients.

Reliance upon the fallacy that the creation of a statutory list automatically bestows upon everyone on it the designation and status of a healthcare professional is a notion that has plagued pharmacy since 2011. This common parlance and the accompanying flawed philosophy that has emerged in government and pharmacy regulatory circles has held back the intelligent debate about skill mix and the future of pharmacy practice that should be had within the profession.

Public officials in government bodies who influence pharmacy in the UK, pharmacy organisations, representative bodies and in particular the GPhC, must not only recognise the vagaries of the current approach, but they must consciously apply this knowledge and act in a more responsible fashion to ensure that it does not diminish public safety when policy on pharmacy workforce and skill mix is being developed.

9.4 Qualifications and responsibilities

The initial training and qualification required to register as a pharmacy technician – NVQ level 3 – is at a low level and arguably insufficiently rigorous for a healthcare technician. It is lower than that required by healthcare technicians in other professions, and lower than that required by pharmacy technicians in many other countries. Pharmacy technicians' NVQ level 3 requirement is equivalent to that for dental nurses, whose duties include helping out on reception, tidying the surgery and sterilising instruments.

Furthermore, 73% of pharmacy technicians in the UK have not even achieved this level of qualification, since they registered via a 'grandparent clause'. Those registered via the

grandparent clause were not required to have any academic qualifications of a fixed minimum national standard to prepare them for the responsibilities of being regulated individuals. They required only those qualifications that they had previously undertaken to enable them to carry out technical aspects of work in the pharmacy (outlined in Chapter 3). Pharmacists countersigning this grandparent clause may have been under the impression that either they had little choice for fear of employer reprisal, or that its only purpose was to maintain the *status quo* in terms of simply codifying the relatively limited duties carried out by members of staff probably previously referred to as “dispensers”. The clause which was countersigned was of limited meaning in any case, given that no clear definition of the pharmacy technician role was provided to signatories. The reliance that can be placed upon the grandparenting authorisation is further undermined by the absence of any record of any assessment having been conducted, by either the RPSGB (the previous regulator) or the GPhC, that the qualifications of grandparented individuals were suitable to allow those holding them to work as pharmacy technicians.

Pharmacy staff in other countries in roles supporting the pharmacist, as pharmacy technicians do in the UK, are generally more highly qualified, often up to degree level. They will often carry out more demanding clinical roles, but where this is the case, as in Denmark, the Netherlands and Sweden, they are often supported by superior clinical governance and risk management systems. The widespread and routine use of clinical information about the patient accompanying the prescription, barcode matching as an integral part of the dispensing process and original pack dispensing, as practised in these countries, remain some way off in the UK.

Adopting a safe culture was an important prerequisite for the development of pharmacy technician roles in these European countries, and their role descriptions had been clearly defined. There are also far more staff working in these European pharmacies, making the proper deployment of staff and supervision of their activities feasible. A much greater focus on safety culture, through the use of technology, for example, and a highly-specific definition of the

pharmacy technician's role, are necessary in the UK before the pharmacy technician's role can be safely developed in the community pharmacy setting.

There is a lack of clarity about exactly what pharmacy technicians in the UK should be responsible and/or accountable for and guidelines remain vague. There is no reference to the term 'accuracy checking technician' in law, for example, and the role can currently be filled by an unregistered, and therefore unregulated, individual. There are only a limited number of precedents in civil and criminal law to suggest the level of liability that pharmacy technicians might experience if cases go to court.

To date, there is little or no evidence to suggest that granting pharmacy technicians additional roles would free up time for pharmacists to deliver patient-facing services.

9.5 Pharmacists' and pharmacy technicians' views on PGDs

Pharmacists' reaction to the suggestion that pharmacy technicians might be granted one particular extended role – that of delivering PGDs – was one of disbelief. There was strong agreement that that such a role could not be delivered without compromising patient safety. Just 1% of community pharmacist respondents to a PDA survey thought that such a proposal would improve patient safety. Pharmacists expressed concerns about pharmacy technicians' qualifications and the level of responsibility and accountability they would have and accept if such an extended role was developed.

9.6 Sectoral differences in the roles of pharmacy technicians

There are clear distinctions between hospital and community practice for pharmacy technicians, and inferences taken from one sector cannot be applied to the other. It is important to note that

hospital pharmacy technicians account for only 21.2% to 39% of the workforce, while those in community represent 53% to 67.4% (see Appendix B). [1] [2]

The majority of pharmacy technicians, mainly working in the community pharmacy sector, carry out a multitude of technical dispensing tasks. A much smaller number, mainly working in secondary care, perform more specialised roles requiring higher levels of clinical expertise.

While a recent RPS report cites numerous examples of high level pharmacy technician practice in the secondary care sector, which is to be welcomed and built upon, the Society's Professional Standards for Hospital Pharmacy Services only specifically mention pharmacy technicians once, and even then only as an example to suggest that accuracy checking pharmacy technicians may be part of the skill mix in hospitals. [8] [9] The conclusion to be drawn from this is not that the standards need to be rewritten, but rather that it suggests that this specialist practice is not yet an integral part of nationally-recognised standards, even in secondary care. Specialist practice among pharmacy technicians appears to be benefiting patient care, but is currently only carried out by highly-qualified pharmacy technicians in specialist secondary care centres, as part of services designed to meet specific local needs, or in some cases in primary care pharmacy settings.

These advanced practitioners are very different to the generalists found in most community pharmacies and hospital dispensaries. Pharmacy technicians working at this advanced level are not representative of the 24,551 registered pharmacy technicians who practise across the different sectors of pharmacy and with varying levels of expertise. [10]

Pharmacy technician practice in hospitals, in terms of training, qualifications, salary, status and structured career framework, is reasonably well developed, as well as being deeply established and well recognised. However, in the community pharmacy setting, these markers are almost

non-existent and there are very few signs that any of these will be established and recognised at any point in the near future.

9.7 The development of pharmacy technician roles in community pharmacy

An improved, enhanced career structure, as outlined in Chapter 8, would allow the more specialised and localised practice currently seen in secondary care to develop and flourish. It would also encourage higher standards in community pharmacy. This could only succeed, however, if the development of a structured career framework for pharmacy technicians arose as a consequence of a similar developmental programme, structured framework and role enhancement having been implemented for pharmacists in community pharmacy. If (and only if) this had been implemented, then specialist services using highly-skilled and qualified pharmacy technicians could be developed in specialised community pharmacy practices, according to local need. The emergence of such a framework based on quality, skills, qualifications and experience and with commensurate salary levels could ultimately help pave the way for a greater transfer of some of the tasks seen in the community pharmacy setting from pharmacists to pharmacy technicians (as proposed in the Scottish Government's 'Prescription for Excellence' vision for pharmacy, for example). [11] Such a framework may already exist in exceptional situations in community pharmacy, but does not exist on any scale large enough to support a national policy on transfer of roles from community pharmacists to community pharmacy technicians.

Those pharmacy technicians currently performing important - but relatively routine - tasks in community pharmacy could continue to do so at **practitioner** level, but the ability to enhance their skills, responsibilities and remuneration would be a viable option for pharmacy technicians via advancement to the **advanced practitioner** level. This nationally-recognised structure would apply also to community pharmacists, and as a consequence it would make the career pathways for both pharmacists and pharmacy technicians - particularly within community pharmacy practice

- more attractive, leading to an improved standard of practice, better retention of staff and ultimately higher standards of care for patients.

The higher standards and regulatory traction gained through such an improved system would enhance public protection and allow pharmacy technicians as an occupational group to develop and flourish, at the same time as maintaining high levels of patient safety. Patient care would improve as pharmacy technicians were enabled to maximise their skills and develop elements of clinical practice that were within the boundaries of their competence. Appropriate use of skill mix would further allow pharmacists to develop their roles in pursuing higher standards of patient care, and enhance the public perception and recognition of pharmacy as a whole.

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