June 2018

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 5

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5 Challenges to the professional status of pharmacy technicians in the UK and reliance upon the capabilities of the group

5.1 Pharmacy technicians – an occupational group or a healthcare profession?

5.1.1 A Health and Care Professions Council definition

The Health and Care Professions Council (previously known as the Health Professions Council) provides a comprehensive definition of what enables an occupational group to become a healthcare profession. One of the conditions it describes is that the occupational group must have an established professional body whose membership accounts for at least 25% of the occupation's practitioners. [1] This suggests that the Health and Care Professions Council believes that professional leadership is a vital component of a healthcare profession.

5.1.2 The APTUK

As highlighted by Howe and Wilson in 2012, pharmacy technicians are lacking representative leadership. In the "Review of Post-Registration Career Development of Pharmacists and Pharmacy Technicians", they stated: "*Strong and representative professional leadership is critical to ensure that the new profession [of pharmacy technicians] is successful in positioning and promoting itself to patients, policy makers and other professions. APTUK faces challenges as the professional leadership body, as it currently has less than 1,000 members out of a registered pharmacy technician population of about 21,000 and its members are predominantly in the secondary care sector.*" [2]

Despite membership being made free for trainee pharmacy technicians in an attempt to increase membership, only 159 trainees had joined the APTUK by November 2013. [3]

The APTUK does not adequately represent the pharmacy technician workforce. Despite being established in 1952, in late 2016 it had just 1,380 members in the UK (more recent figures could not be found at the time of writing in 2018). [4] This would represent just 6%

of the total workforce in Great Britain of 23,150 (however, some of the APTUK's members may be based in Northern Ireland, meaning that it represents even less than 6% of the total UK pharmacy technician workforce). [4] In addition, it has previously been estimated that around two thirds of pharmacy technicians work in the community setting and the majority of the remainder are employed to work in hospital pharmacies; it was said at the APTUK launch of the 'Identifying the roles of Pharmacy Technicians in the UK' report in October 2016 that the APTUK has the opposite proportions in membership. Indeed, it is stated in the report that the APTUK's membership is "*largely derived from the hospital sector.*" [99] [5] These issues drastically limit the APTUK's ability to provide leadership of the registrant group and constitute an inability to satisfy the healthcare profession criteria described by the Health Professions Council.

In contrast, 6,073 qualified dispensing opticians are members of the Association of British Dispensing Opticians (ABDO), which also has 519 members overseas, 420 associate members, 1,722 student members and 362 members in other categories (according to its 2017 annual report). [6] This is out of a total of 6,705 dispensing opticians registered with the General Optical Council (as at 31st March 2017). [7] The Dental Technologists Association advised the PDA in November 2018 that it had around 1,600 members out of a total registered dental technician workforce of 6,088 (as at November 2018). [8]

As at November 2018, full membership of the APTUK costs £48 per year. Membership costs £24 for fellows, £14 for 'associate members' (ex full members no longer in gainful employment) and is free for trainee pharmacy technicians. This level of fee is unlikely to provide it with sufficient resources to lead the group with any great conviction.

Howe and Wilson said: "*The officers and executive of APTUK carry out their duties on a voluntary basis, which puts considerable pressure on them as individuals representing an emerging profession at a time of great change in healthcare education, training and service delivery.*" [2]

Whilst the APTUK appears to support the delegation of responsibilities from pharmacists to pharmacy technicians, despite the numerous risks to patient safety (which are set out in this report), paradoxically it has expressed concerns about the delegation of the activities undertaken by pharmacy technicians to dispensing assistants. [9] As mentioned earlier, it has been recognised that the roles of pharmacy technicians and dispensing assistants in community pharmacy are essentially the same.

Only relatively senior technicians are members of the APTUK executive. As at February 2017, according to the APTUK website, of its 20 officers, almost all work in mid-senior or senior pharmacy technician positions. With one exception, all were either currently working in the hospital sector or had previously done so. Three officers had current roles primarily focused on education and one had a role in medicines information. Just three were working in community pharmacy and each of these on a part-time basis, balanced with managerial responsibilities or other roles in education.

The situation was similar when re-examined in November 2017, though only 14 officers were reportedly in post. Of those, ten were currently working in the hospital sector and three who were not had previously done so; the one officer who had not worked in the hospital sector had a career in primary care. All worked in mid-senior or senior pharmacy technician positions. Just one of the officers currently worked in community pharmacy on a part-time basis, his role as a pharmacy technician balanced with managerial responsibilities. The APTUK's website detailed three other officers with apparent previous community pharmacy experience as a pharmacy technician (in one case this was at some unspecified point since the 1970s; one officer worked in an independent pharmacy from 2014 to 2016 and another worked from 2009 to 2010 in a community pharmacy before leaving to pursue a career in hospital pharmacy). Three officers had current roles primarily focused on education and one had a role in medicines information. [10]

The APTUK's website indicates that the organisation is supported by a number of pharmaceutical companies (Special Products, Nova Laboratories Ltd, Pfizer, AAH and Sintek). [11] Whether these companies provide financial support to the APTUK, and the nature of their interest in its success, is unclear.

Despite significant challenges facing the credibility of the APTUK, the voluntary nature of its executive, its financial constraints and sectoral focus, its representatives are invited to sit on most of the relevant government developmental groups. This could give policy makers the impression that it not only represents all pharmacy technicians, but that the standard of its officials is representative of those seen among pharmacy technicians as a whole. This is not the case, as most pharmacy technicians work in community pharmacy and practise at a different level to APTUK representatives.

The president of the APTUK, Tess Fenn, contacted the PDA by email in June 2018 about the publication of this report. She said: *"Incidentally for information, I am a grand parented Pharmacy Technician with, at the time of entry onto the GPhC register (2011) 41 years' experience ranging from hospital, community, primary care and academia. I also have a number of pharmacy accreditations in accuracy checking & medicines management, leadership and management qualifications as well as a degree in my specialist area. I have trained and mentored countless pre-registration pharmacists and have supported many pharmacists in their early years, particularly in exercising their professional judgment.*
I am not alone, by any means, and many pharmacy technicians have masters degrees as well as a myriad of post registration qualifications.
I hope this is recognised in your report." This helps illustrate the point made above. The APTUK president and pharmacy technicians with *"masters degrees and a myriad of post-registration qualifications"* must not be taken to be representative of the vast majority of pharmacy technicians, whose education and training requirements have been examined elsewhere in this report and fall far below these standards.

Since it is the policy relating to skill mix and pharmacy technicians working in the community pharmacy setting that is currently under substantial review by the government's Rebalancing Medicines Legislation and Pharmacy Regulation programme board, the fact that there is no meaningful representation - nor even a significant membership constituency - of community pharmacy-based members within the APTUK, is cause for concern.

Professional interests are borne out of a collective ambition and lead to the creation of a strong representative voice. If there is no strong representative voice, then, arguably, the collective ambition may not exist. Undoubtedly pharmacy technicians should organise themselves into a body, such as the APTUK, and press for developmental progress; encouraging standards and provide learning for their members. The APTUK, however, cannot currently be described as meeting the definition of a professional body, even if that is how it chooses to describe itself or what the government, keen to pursue its skill mix agenda, would prefer it to be.

Despite the fact that APTUK representatives cannot provide wide-scale grassroots input into this process or adequately represent the views of pharmacy technicians in community pharmacy, the programme board has placed great store upon the fact that its representatives have been involved as board members from the outset. This not only conspires to further undermine the leadership and representative credentials of the APTUK, but also the validity of the government's entire Rebalancing Medicines Legislation and Pharmacy Regulation programme.

5.2   Acting professionally or being a professional?

A lack of clarity and transparency and the influence of historic employment practices has meant that there has been little debate about the roles and the professional status of pharmacy technicians in the community pharmacy setting. This has hampered the progress of skill mix development between pharmacists and pharmacy technicians.

The PDA as a pharmacist organisation does not have pharmacy technicians in its membership. However, it recognises that pharmacy technicians are the valued colleagues, who work alongside our members every day. They are often friends, family and fellow employees, working together as a team. The PDA wishes to see the development of the roles of pharmacy technicians and it recognises that there are already some areas of pharmacy practice in hospitals, primary care and in some parts of the manufacturing process where pharmacy technicians are operating in a very professional way and without their involvement, the respective service would suffer. Although it does exist, this is however, far less evident in the community pharmacy sector.

Compulsory registration of pharmacy technicians in Great Britain was introduced in July 2011. This was an attempt to improve protection for patients, by seeking to ensure that all pharmacy technicians employed in pharmacy - who play a part in the provision of pharmacy services - would be properly trained and under a duty to keep up-to-date and maintain high standards. After that date, anyone not registered - but working - as a pharmacy technician, or referring to himself/herself as such, would be breaking the law and could face prosecution. Pharmacy technicians became accountable for their practice and were expected to understand the limits of their own responsibilities, capability, knowledge and understanding, and when to refer to others.

Evidence indicates that many pharmacy technicians do not view themselves as professionals as they do not feel that they should be held personally accountable for their own actions. For example, in a study conducted by JRA research on behalf of the PDA, the majority of those surveyed who were working in the community pharmacy setting believed that the pharmacist would still take responsibility for their actions. [12]

This is perhaps unsurprising. There is significant concern that in pharmacy, the phrases 'acting professionally' and 'being a professional' are being used almost interchangeably and are thought of as such by some. This is not at all helpful. The use of the word 'professional'

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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. A sixteen-year-old receptionist or fast food server with no qualifications whatsoever, can, with good manners and a little organisational knowledge, seem to act professionally in a relatively simple customer transaction - but no rigorous or objective assessment could describe the person as being 'a professional' or part of a profession.

It is hoped that any staff member of a pharmacy in the UK would be able to act professionally when facing a patient or customer, but this does not mean that it would be appropriate to describe him or her as 'a professional' or the group as 'professionals'. Neither did the creation of a register of personnel on one particular day mean that all those appearing on it from that day on became 'professionals' or that the group could be described as 'a profession'.

Yet this is an issue that plagues pharmacy in the UK. In 2011, as a result of an initiative driven by civil servants, an administrative register of pharmacy technicians was created. This in itself would not be a problem as such, but since that day, those who would wish to hasten the process of skill mix development in pharmacy and see roles delegated by pharmacists to pharmacy technicians in short order have contributed considerably to the confusion, and harmed the debate about what being a professional in pharmacy is all about. Increasingly, pharmacy technicians, without sufficient justification, are being described as professionals, 'pharmacy professionals' or members of a profession.

The register of pharmacy technicians was a policy construct of the civil service. Whilst it is fully recognised that there are a number of highly capable and competent pharmacy technicians, the collective group - being described as 'a profession' by civil servants - did not emerge through a robust and traditional process of professional consciousness being gradually built up, layer by layer over a period of time and in response to changes in healthcare delivery. It was not developed by a group that could exhibit highly specialised

and distinct skills, expert knowledge and rigorous high-level training. The group is not represented by a strong leadership body who could represent and articulate its ambitions. Pharmacy technicians, therefore, should not be considered as a group whose registration confers anything like the same protection to the public as for a professional group that emerged through the more traditional route, such as pharmacists.

What exists instead is one profession, formed by pharmacists over many generations and in the traditional way, and one register of pharmacy technicians that was created recently on a particular date by government edict. Consequently, many of those on the pharmacy technician register are separated by great differences in training, experience, capability, appreciation of their accountabilities and, most importantly of all, widely differing ambitions. As has already been discussed, the majority of pharmacy technicians on the register were grandparented on to it. They did not join a profession in the common sense of the word; they came to work as usual and on one particular day, it became a requirement for their names to be entered onto a register; as such, the register 'joined them'.

This is an extremely important concept to bear in mind, especially when considering how best to develop a symbiotic and complementary skill mix in pharmacy. The debate should be about identifying the vision for the future of pharmacy practice and the respective future roles of pharmacists. Only then will it be possible to establish what roles pharmacy technicians might undertake to best provide support to pharmacists, so as to allow the development of the profession of pharmacy and drive benefits to patients. It should be about learning what makes the very best pharmacy technicians so good, then recognising and overcoming the challenges that would bring the rest up to that standard, which could then be quality-assured. It is also about recognising and understanding the significant differences between pharmacy technicians in the hospital setting who routinely work in a very professional way, where standards have been developed over many years with the support of senior hospital pharmacists, and those in the community setting, where pharmacy technician development has been held back by a lack of investment by

community pharmacy employers (a situation which is likely to continue in the absence of any significant regulatory or government intervention coupled with funding support). It should also be a debate about recognising what has worked in other countries and why. Ultimately, the debate should be held by the profession and should be about how best to develop high standards amongst such a large and disparate group of pharmacy technicians, in a way that benefits patients.

5.2.1   Continuing fitness to practise (CFtP) and the renaming to "revalidation"

Those reviewing CPD records submissions from pharmacists and pharmacy technicians have, for some years, generally been checking whether all the necessary fields have been completed in the GPhC's online CPD recording system.

The GPhC agreed in 2014 to establish a CFtP advisory group, which comprised of stakeholders from the government, pharmacy organisations and an organisation representing patients. [13] [14] [15] In 2016, the GPhC invited all of its registrant pharmacists and pharmacy technicians to participate in a study on a proposed new framework and requirements for demonstrating continuing fitness to practise.

Among the circa 23,000 registered pharmacy technicians, 301 registered to participate in the CPD pilot and 85 completed all required elements. Therefore, 28% of pharmacy technicians who registered for the pilot completed all required activities, which equates to 0.37% of all pharmacy technicians on the register. By comparison, 495 (47%) of pharmacists who registered for the pilot completed all required activities, which equates to 0.92% of all registered pharmacists. [16] [17]

Beyond the issues with pharmacy technician engagement in the process, it is of concern that the public is being led to believe that pharmacy technicians will be subject to a revalidation process. In April 2017, around three weeks before the launch of the consultation, the GPhC renamed the CFtP programme and framework to "revalidation", in the face of opposition

from key senior and experienced officials at the GPhC and without consulting the CFtP advisory group. Revalidation has very specific meaning relating to a particular method of assuring continuing fitness to practise. [18]

The CFtP Interim Evaluation Report prepared by Solutions for Public Health and shared with the CFtP advisory group in December 2016 stated: "*Given the PSA guidance on the CFtP model being proportionate to risk, the GPhC's focus on continuing improvement in practice as opposed to formal assessment for revalidation makes sense.*" [19] Those words were removed and were not present in the final evaluation report published online by the GPhC, meaning that the information was not available to consultation respondents other than those who had received it due to their involvement in the advisory group. [16] The GPhC had said the same to the CFtP advisory group before the consultation – that the framework did not constitute revalidation because, inter alia, it did not include a formal assessment of practice by a suitable person. However, in a statement reported on by the pharmacy media on 8 December 2017, the Chairman of the GPhC's governing council said that the GPhC had been working towards revalidation for a number of years. [20] [21]

The GPhC may sample records from only 2.5% of registrants each year, reviewing only the previous year's records and providing three chances to produce satisfactory records before taking punitive action. [19] [22] Under these arrangements, it will face difficulties in determining whether pharmacy technicians have appropriately developed themselves. This will be compounded by the absence of a clear role definition and with what appears to be a low level of engagement from pharmacy technicians in the process.

Much of the basis of revalidation arose from the Shipman Inquiry and it is a concept that the PDA supports. However, the framework introduced by the GPhC does not amount to revalidation – because it lacks a periodic check by another suitable person on the registrant's fitness to practise and does not meet the definitions put forward by the

Professional Standards Authority (PSA), the DoH and others. [19] [18] [23] [24] [25] [26] [27] [28] [29] [30] [31] [32]

It appears that the framework being introduced does not meet the GPhC's own definition of revalidation. At a meeting in November 2013, the GPhC's governing council explored a means of implementing a framework for assuring continuing fitness to practise. The meeting papers stated: "*The terms 'revalidation' and 'continuing fitness to practise' are subtly different. In the GPhC's view 'revalidation' implies a fixed point assessment whereas 'continuing fitness to practise' suggests a review of practice viewed on a continuum. The latter better describes the thinking outlined in this proposal, so that term will be used from now on.*" [33] In 2014, a page was created on the GPhC's website explaining why it was looking to implement a CFtP framework and not revalidation. On that page, under the heading "*What happened to revalidation?*", it stated: "*We have been working on the introduction of new arrangements for assuring continuing fitness to practise for some time, and initially this was called 'revalidation'. We have decided not to use the word 'revalidation' anymore because it has a very specific meaning relating to a particular method of assuring continuing fitness to practise.*" [34] As at 5 February 2017, this had been changed to "*We have been working on the introduction of new arrangements for further assuring standards for safe and effective pharmacy practice for some time, and initially this was called 'revalidation' We have decided not to use this term anymore because it was not well understood.*" [35] The webpage has since been removed from the GPhC's website. In the version of the evaluation report of the CFtP pilot published on the GPhC's website in February 2017, it explains that the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) revalidation models include a fixed-point assessment of the registrant's fitness to practise. The report confirms the GPhC's continued commitment at that point not to develop a revalidation model (which it had earlier said implies a fixed-point assessment): "*The GPhC's direction of travel is to move away from a process of a fixed point assessment for assurance… Given the PSA guidance on the CFtP model being proportionate to risk, this makes sense.*" [16]

That the framework does not amount to revalidation was acknowledged by the GPhC and other pharmacy stakeholders at a CFtP advisory group meeting on 11 October 2017. The advisory group requested that the GPhC's governing council be asked, at its meeting the following day, to change the name of the framework from "revalidation" to an alternative which accurately reflects its nature. The advisory group was subsequently informed by email on 1 November 2017 that the council had decided to retain the name *"because of its relative ease of understanding and they felt we needed to do more to explain the type of assurance that it provided to the public"*. There is no record in the minutes of the council's meeting of 12 October 2017 of this being discussed, though revalidation was discussed. [36] [37] This reasoning seemingly contradicts the position the GPhC took in February 2017 - that the term 'revalidation' was "*not well understood*". [35] The council's public position appears notably silent on the potential inaccuracy and inappropriateness of the title 'revalidation'; this title may altogether mislead the public in respect of the level of protection afforded by the framework, each time it is used.

In essence, there are concerns about the process termed "revalidation" that will be used by the GPhC. For pharmacy technicians, when all of the other factors are taken into account, this adds further concerns about the perceived and actual quality assurance of the work of this occupational group.

5.3   Recommendations of the Francis Inquiries

The failures at the Mid Staffordshire NHS Foundation Trust between 2005 and 2009 resulted in a public outcry and led to two separate inquiries, each chaired by Sir Robert Francis QC. The reports were published in 2010 and 2013 respectively and took a panoramic look at the genesis of many of the failures. The inquiries tried to establish the fundamental causes, rather than just observing the publicly visible symptoms, and made many clear recommendations for the future.

One of the matters considered was the adverse consequences that can occur when policy is forced top-down by management or policy makers upon groups of healthcare staff working at the coalface. The reports made the case for how important it was for senior management and policy makers, particularly in the Department of Health, to make sure that any changes in policy relating to service delivery have the input of coalface practitioners. Two substantive recommendations were made in this regard:

- *"All changes in service delivery, systems, equipment, staffing and resources must be measured against the impact on the standard of service provided. Therefore, no change should be authorised or implemented without:*
    - *timely, and recorded, consultation with professional staff who are to deliver or whose service will be affected by the proposed change;*
    - *a proportionate, thorough and objective impact assessment, recorded in writing."* [38]
- *"The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being."* [39]

5.4 The approach being taken by the Rebalancing Medicines Legislation and Pharmacy Regulation programme board

The Department of Health (DoH) established the Rebalancing Medicines Legislation and Pharmacy Regulation programme board (Rebalancing board) in 2013. [40] [41] It continues to operate in 2018. [41] This board seeks, through changes in pharmacy supervision arrangements and skill mix, to change the way in which pharmacists and pharmacy technicians operate, particularly in the community pharmacy setting. Potentially, this exercise could fundamentally change the roles and responsibilities of both pharmacists and pharmacy technicians.

Far from recognising the risks identified in the Francis inquiries relating to top-down policy determination - which fails to engage and secure the support of grassroots practitioners - the DoH has not encouraged wide discussion about skill mix in pharmacy. Nor has it invited

many of the key national representative bodies of the groups who will be most affected by these changes - pharmacists and pharmacy technicians working in the community pharmacy sector - to discuss the issues, make their contributions and express any concerns that they may have. The Rebalancing board instead receives its input from a small and exclusive group of individuals, hand-picked by the DoH, and a stakeholder reference group that has been called upon to offer its input on only a small number of occasions since 2013.

It is apposite to consider that a recent survey of pharmacy technicians in the workplace demonstrates that it is possible to solicit views in a way that provides contemporary opinions from pharmacy technicians working at the coalface. [12]

There appears to be a great reluctance to allow the pharmacy profession to engage in and lead the debate and to develop skill mix, as it did successfully in the hospital sector in the 1980s. Instead, the civil service, having constructed a register of pharmacy technicians, now seems keen to orchestrate its own internal discussion process and impose its own preferred skill mix arrangements. The government has decreed that it will develop skill mix and the role of pharmacy technicians through the establishment of an exclusive Rebalancing board, to which members are appointed by the government, where the minutes and agendas are carefully prepared and managed by civil servants and from which the wider pharmacy profession is largely excluded.

It is therefore unsurprising that this way of working has left the pharmacy profession not only largely disengaged from the process, but also highly suspicious of the government's intentions. All of the previous examples of the successful development of skill mix, whether in pharmacy or elsewhere (for example in Mental Health Trusts as a result of the New Ways of Working programme), show that skill mix can only be developed successfully with the full engagement and active buy-in of key stakeholders. [42]

5.5   Acting professionally or being a professional, and the use of terminology

The notion that someone who can '*be* professional' (adjective) is the same as being '*a professional*' (noun) or that because pharmacy technicians now appear on a register, they can be considered to be professionals, in the absence of any of the other underpinning professional attributes, is a fallacy. Reliance upon this fallacy through the common parlance that has emerged in government circles has not only held back the intelligent debate about skill mix and the future of pharmacy practice that should be had within the profession, but also presents risks to the public.

Though it appears that considerable effort is expended to maintain the parlance, occasional lapses - from the GPhC and the APTUK, for example - betray it. To illustrate this, the GPhC made the distinction between pharmacy professionals and pharmacy technicians in its 2015 '*fees rules and consultation analysis*'. [43] A further instance arose when the APTUK and the University of East Anglia stated in a 2016 publication that "*in parallel with developments seen within the pharmacy profession pharmacy technicians are found to be providing more patient facing services*", making the distinction between the pharmacy profession and pharmacy technicians. The organisations also stated, in reference to pharmacy technicians, "*additionally it would provide some research training and thereby empower the profession to develop its own unique knowledge base, which has been identified as a requirement for obtaining professional status*", thereby acknowledging that professional status had not been achieved. [4] However, due to the inappropriate use of the term 'pharmacy professional' by the regulator, the DoH, in training materials and even in academic pharmacy-related publications, in some cases it is impossible to tell whether the term is being used in reference to a pharmacist or pharmacy technician, undermining the confidence that can be invested in the term in a given context.

The use of the term "pharmacy professional" in training materials may indicate or suggest that the training has been rendered inappropriately simplistic such that it won't meet pharmacists' needs. It may undermine the confidence that pharmacists will have in that

training and result in the training not being completed. Alternatively, where it has been designed to accommodate pharmacy technicians as the target audience, it may lead to knowledge gaps for pharmacists of which they may not be cognisant. As an example which illustrates the use of the term, in October 2017 the Centre for Pharmacy Postgraduate Education (CPPE) issued some learning materials about mental health designed to be read by both GPhC-registered pharmacists and pharmacy technicians. [44] [45]

The overuse of non-professional occupational groups in healthcare has led to stark warnings in other fields of practice. A study published in 2016 of data pertaining to the period from 2009 to 2011 found that higher healthcare support worker staffing was associated with higher levels of risk-adjusted mortality in an analysis of 137 NHS trusts. Higher doctor staffing levels, on the other hand, lowered mortality rates. In a subsample of 31 trusts, higher nurse staffing levels were significantly associated with lower mortality among both medical and surgical patients in the adjusted model used. Other studies which have considered less-highly-qualified nursing staff in hospitals (licensed practical nurses and unlicensed support workers) have shown higher numbers of less trained staff or a diluted nursing skill mix to be associated with higher mortality or lower cost-effectiveness. [46]

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 manner to ensure that it does not diminish public safety when policy on pharmacy workforce and skill mix is being developed.

The approach currently being taken by the DoH to developing skill mix in community pharmacy represents a significant hurdle to the development of the roles of both pharmacists and pharmacy technicians in that setting. It creates suspicion and concern among pharmacists and erodes the very culture of pharmacist buy-in and support that

would be needed to enable the natural and successful development of skill mix in community pharmacy.

5.6 Public trust and confidence in pharmacists

Pharmacists are regarded by the public as among the most trusted health professionals. A study by Ipsos MORI, commissioned by the GPhC and published in January 2015, found that 87% of the 1,115 respondents said they trusted health advice from a pharmacist either a great deal or a fair amount. This was similar to the result for opticians (88%), dentists (90%) and nurses (91%), though there was scope to improve the percentage who said 'a great deal'. [47] A survey of 2,002 people, carried out by ICM research limited in March 2015, found that respondents held pharmacists as the most trusted profession among those studied (which included doctors, nurses, accountants, solicitors and police officers), with 97% generally or completely trusting the profession. [48] Additionally, at both a global and European level, pharmacists rank highly among the most trusted professions. [49] Pharmacy technicians did not feature in these studies. The public must not be misled in to thinking that they can place similar trust in the training and capabilities of pharmacy technicians as they do in that of pharmacists. It is therefore vital that public trust and confidence in pharmacists is not undermined by the inappropriate use of 'pharmacy professional' to refer collectively to pharmacists and pharmacy technicians.

5.7 Remote supervision

Proposals were put forward by the DoH in 2006 to enable remote supervision – where a pharmacist would supervise the pharmacy and/or its activities without being physically present. At the same time, the DoH also proposed allowing pharmacists to supervise more than one pharmacy at the same time and enabling pharmacists to delegate certain aspects of supervision to pharmacy technicians. The proposals received strong opposition in the House of Lords and from MPs on the basis of patient safety, that the quality of service and advice would be lost without the guarantee that a pharmacist would be present in the pharmacy and because the prevailing commercial reality in pharmacy would mean that

"companies with several pharmacies will simply reduce the number of qualified pharmacists they employ in some areas". [50] [51] [52] [53] [54] [55] [56] [57]

The proposals were to be achieved through a change to the Medicines Act 1968, whilst a health bill (which led to the Health Act 2006) was being debated by the government. Lord Warner, Minister of State for the Department of Health, said: *"Through this power [a proposed amendment to the Medicines Act 1968] we can specify which activities pharmacists must undertake themselves and when aspects of the preparation and assembly of a medicine can be delegated to other trained and competent pharmacy staff working under the supervision of the pharmacist. This power also enables us to prescribe conditions that must be met where a pharmacist supervises these activities remotely. However, the power does not relate to our proposals to enable the responsible pharmacist to delegate certain aspects of supervision for suitably trained and registered health professionals such as pharmacy technicians…"*. [58] [59] [60]

The debate about remote supervision is ongoing and being conducted through the Department of Health's Rebalancing Medicines Legislation and Pharmacy Regulation programme board, without the input of the wider profession of employee and locum pharmacists or their representatives, and without resolving some of the significant risks identified in this report. In a research study published in 2015, whose participants included community and hospital pharmacy employers, hospitals, education providers, awarding bodies and leadership bodies, an interviewee stated *"With the current rebalancing and changes to legislation, the role of the pharmacy technician can become really important, not just in terms of supervision but in what they can deliver to the patient in the absence of a pharmacist"*. [61]

In April 2015, the APTUK told the government, the Rebalancing board and other pharmacy bodies that pharmacy technicians should be able to make the final accuracy check on

dispensed items, hand out dispensed prescriptions and sell P medicines in the absence of a pharmacist, to allow the pharmacist to 'pop out for half an hour'. [62]

In September 2017, a previously undisclosed document from the Rebalancing board was leaked to the *Chemist and Druggist*. The board's supervision working group had proposed that pharmacy technicians be able to supervise the supply of pharmacy-only (P) and prescription-only medicines (POMs) and oversee the activities of other, non-regulated pharmacy staff in either the presence or absence of a pharmacist. The supervision Short Life Working group that generated this proposal was made up of two of the UK Chief Pharmaceutical Officers, the RPS President, the manager of Pharmacy Forum NI, a senior representative of the PSNI, a senior representative of (the now disbanded) Pharmacy Voice, a senior representative of the GPhC and the President of the Association of Pharmacy Technicians UK (APTUK).

Apparently cognisant of some of the shortcomings in the proposals, the board acknowledged that "*There are likely to be concerns about the competency of some registered pharmacy technicians to undertake this new function*" and said "*Those with responsibility for the overall governance [of a pharmacy] can be expected quite reasonably to ask: 'How do I know that my registered pharmacy technician is trained and competent to undertake this new function?*" However, whilst the board received and accepted the proposals in principle on 7 April 2016, it agreed unanimously that they should not be discussed publicly by board members. The papers were marked 'sensitive' and 'not for wider circulation'. [63]

In the context of the leak, some stakeholders may have anticipated insight and regret from the Rebalancing board in relation to the consequences of its decision not to involve the wider profession in developing the supervision proposals (wider involvement would have been in accordance with the recommendations of the Francis inquiries mentioned in section 5.2), alongside a determination to do so from that point onwards. However, what was

expressed instead was frustration and disappointment that the proposals had been leaked. [64]

The Pharmaceutical Group of the European Union (PGEU), which represents organisations of pharmacists and pharmacy owners in 32 European countries, said in response: "*While fully appreciating the value of pharmacy technicians and other pharmacy support staff in the pharmacy team… the immediate availability of Pharmacists to deal with patient requests and to supervise other members of the pharmacy team is an indispensable element in ensuring patient safety. After all, we would not accept pilots without the highest level of qualification flying commercial planes. But Europe's citizens are exposed to far greater risk from medicine misuse than from air traffic accidents. Other EU Governments have previously considered equivalent policies, but have ultimately rejected them because they recognise the importance of having Pharmacists available in Pharmacies to deal with the breadth and depth of patient care issues which arise… Other members of the pharmacy team, such as technicians, while playing an important role in the pharmacy do not hold the same level of education and professional training (and in some cases ethical obligation) and therefore cannot hold the responsibility to the patient.*" [65]

The Commonwealth Pharmacists' Association, whose website says it represents over forty national professional associations, said of the proposals: "*Whilst the Commonwealth Pharmacists' Association (CPA) fully appreciates the value of technicians in the pharmacy team, we need to consider the wider implications that such a message would send to the global community… [the proposals] would be a disaster for lower and middle-income countries trying so desperately to establish a healthcare structure with 'quality' at the heart of it.*" [66] [67]

5.8   GPhC involvement in supervision proposals

The GPhC was represented on the Rebalancing board and on its supervision working group - which developed the leaked proposals on pharmacy supervision in early 2016. The same is true of the PSNI, though it does not regulate pharmacy technicians.

In December 2016, in the absence of an agreed role definition for pharmacy technicians, the GPhC consulted on changes to the standards for the initial education and training of pharmacy technicians. It may appear, in the context of the leaked supervision proposals from the Rebalancing board, that the revised standards were developed with the proposed changes to supervision in mind. The consultation document stated: *"[The standards must]… prepare pharmacy technicians of the future to take on increasing roles and responsibilities, if employers (both in the NHS and independent sectors) want this and if governments across Great Britain propose changes to legislation. This document sets out draft standards for the initial education and training (IET) of pharmacy technicians that are designed to reflect this."* It is notable that the GPhC had set the standards based on what *employers* might want, as opposed to what *registrants and the public* might want and also what the capabilities of pharmacy technicians might make appropriate. However, in a statement on 11 September 2017 which appeared to contradict the GPhC's statement in the December 2016 consultation, the GPhC's Chief Executive and Registrar stated that the changes to the standards were "*completely separate from [the issue] of whether the government at some point might bring forward proposals to change the law… The education and training standards… are of course in the context of existing law, which does not provide for technicians to supervise medicines transactions.*" [68]

The standards include "*Confirm the suitability of a person's medicines for use*" and "*Issue prescribed items safely and effectively and take action to deal with discrepancies*", which could be interpreted very broadly indeed. The standards also include "*Carry out an accuracy check of dispensed medicines and products*". On examination, these standards may appear to be linked to the Rebalancing board's supervision proposals. The GPhC expects that

pharmacy technicians should achieve these learning outcomes at the highest competency level on the Miller's triangle ('does'). [69] Due to the vague wording of these outcomes, it may even be interpreted that for pharmacy technicians to achieve them, they would need to be able to clinically check prescriptions; this is a skill which takes pharmacists five years of full-time training and a masters level degree to accomplish. This would have serious implications for patient safety. [70]

The GPhC also consulted from July to October 2017 about plans to cease setting training requirements and assessing and approving training courses for dispensing and medicines counter assistants. At the time of writing, anyone working in a pharmacy as a Medicines Counter Assistant must have undertaken an accredited Medicines Counter Assistant course, or have commenced such training within three months. [71] [72] It is likely that many pharmacy technicians will not have undertaken this training, since it may have been unnecessary for their roles (this may be the case in community pharmacy as well as in other sectors). The GPhC's proposals would have removed an important safety mechanism. The changes it proposed would have meant that employers had much more influence in determining and controlling the level of training required to carry out the sale and supply of P medicines - where it is currently determined by the regulator. [73] [74] The GPhC said that some respondents had *"concerns about patient safety risks"* if there was "*no GPhC quality assurance of training programmes for unregistered pharmacy staff*". [75] The GPhC decided not to proceed but indicated that it may make changes in the future, saying "*After considering the feedback to the consultation the Council decided that further work was needed to develop the future approach. The initial training requirements for unregistered members of the pharmacy team and accreditation of courses will remain the same while this work is taken forward.*" [76]

5.9 Pharmacy technicians as a newly-regulated group

A review undertaken as part of the 2012 Modernising Pharmacy Careers (MPC) programme stated that pharmacy technicians have simply *"moved from essentially what was an*

'occupation' to a 'professional' role", citing only an article in 'Hospital Pharmacist' in 2006. [2] [77] It would be flawed to assume that registration with a healthcare regulator instantaneously resulted in the creation of a profession. It did not, nor should it have done. Consequently, the register of pharmacy technicians does not carry the same professional and patient safety connotations as does, for example, the register of pharmacists, dentists or doctors. In fact, the aforementioned article in Hospital Pharmacist was misquoted in the MPC report; it did not say that professional status would be achieved through statutory registration with a regulator. The themes it raised have been explored in much greater depth in this report.

Post-registration pharmacy technicians are now faced with new challenges: they have been thrust into a regulatory framework through a government initiative and now have a personal responsibility for identifying their own development needs regarding knowledge and competence and maintaining and updating their own practice. This is a process for which many of them, particularly those working in the community pharmacy setting, have little or no experience.

The MPC Review recognised these concerns and warned that *"this culture change may take some time to embed across what is a very diverse professional group in terms of education and training and scope of practice. Pharmacy technicians will require a degree of support to smooth the transition as they are socialised into new ways of working."* [2]

Research has shown that pharmacy technicians generally have little understanding of the implications of registering with a healthcare regulator, in terms of what this means for their roles and responsibilities. Results of a survey indicated that 78% of pharmacy technicians registered with the GPhC in the first place because they were required to do so by their employer or because this was a condition of their continued employment. This lack of professional awareness has perhaps been reinforced for many by the fact there has been no change in their roles or remuneration as a result of their registration. Only a small

proportion (17%) indicated that they registered because they had an ambition to pursue a career as a pharmacy technician. Added to these issues is the concern that 69% of pharmacy technicians surveyed believed that in the event they made a dispensing error, it would be the pharmacist or superintendent who would be held most accountable by the GPhC, whereas only 30% believed it would be themselves. [12] The MPC review concluded that *"There needs to be shared agreement about responsibility and accountability between employers, pharmacists and pharmacy technicians."* [2]

5.10 Accuracy checking technicians

The variety of roles that registered pharmacy technicians undertake, particularly in the hospital pharmacy sector when compared with the community sector, has led to a debate regarding the scope of practice, competence and responsibilities of the newly-registered group. [78] [79]

A task completed by some pharmacy technicians with additional training is the final accuracy checking of dispensed items, where the clinical check has been completed by the pharmacist.

The Royal Pharmaceutical Society (RPS) has argued that accuracy checking technicians (ACTs) *should* be registered pharmacy technicians, however, there is no legal or regulatory requirement that ACTs *must* be registered pharmacy technicians. [80] Neither are there any legal or regulatory requirements in relation to the qualifications that an ACT must undertake to perform the task. The ACT role does not have a protected title or a legal definition. This means that in theory, any person, with or without training, though they may not be able to call themselves a pharmacy technician, could claim to be an ACT and practise as such. A search in March 2017 for ACT job vacancies advertised by the CCA multiples, accompanied by a wider internet search on recruitment websites for all relevant community pharmacy vacancies, revealed some large multiple, smaller multiple and independent community pharmacy employers who specified that candidates must possess an accuracy checking

certificate but not that they must be registered with the General Pharmaceutical Council as a pharmacy technician. It is unclear whether this would have been insisted upon at a later stage in the recruitment process, but certainly no restrictions were involved at the application stage.

The "Nationally Recognised Competency Framework for Pharmacy Technicians - Final Accuracy Checking of Dispensed Items" recommends that 1,000 prescription items be checked without error for the ACT qualification. [81] The document has advisory status only. Community pharmacy employers may require this to be achieved but may allow "banking", for example after every 200 items checked correctly, with further attempts permitted if an item is accuracy-checked incorrectly.

Buttercups provides an online course for dispensing assistants to train to complete the final accuracy check on dispensed medicines. Dispensing assistants are required to complete an accuracy check of 1,000 dispensed items, which have to be second-checked by either a pharmacist or "checking technician". The checked items may be "banked" every 200 items; if a "serious error" is made, the set of 200 must be restarted. If a "minor error" is made, the dispensing assistant can continue the set of 200 without having to start again from the beginning of that set. Buttercups does not provide definitions of "minor error", "serious error" or "checking technician" on its website. [82] The RPS accredited the training content, seemingly at odds with its recommendation that only pharmacy technicians should be able to work as ACTs. [82]

The GPhC has not addressed calls for clarification on the apportionment of professional responsibility, has not stipulated that accuracy checking must be restricted to registered pharmacy technicians as standard and has not commented on what (if any) training in accuracy checking is necessary. [79] Furthermore, it has stated no intention to recognise ACTs via annotation on the public register of pharmacy technicians. [79]

However, the GPhC's position in relation to the status of registered pharmacy technicians was clarified at a recent RPS Conference when the Chairman of the GPhC's governing council explained that due to very variable standards among pharmacy technicians, it was not possible for the regulator to take a blanket view and to recommend to pharmacists what roles they should delegate to pharmacy technicians (see section 3.7).

In the meantime, however, some individuals practising as ACTs are registered pharmacy technicians, providing at least some degree of regulatory protection, while others are not required to be so. Many employers place great emphasis on the role of ACTs as opposed to pharmacy technicians, requiring pharmacists to pass the final checking of prescriptions over to these individuals prior to the final handout to patients. This is creating doubt and concern among pharmacists about the delegation of tasks and about the personal liabilities that they would face in the event of an error.

5.11 GPhC understanding of the accountability for the final accuracy check of dispensed medicines

The lack of understanding of accountability among senior staff at the GPhC, in respect of the final accuracy check of dispensed prescription items, was demonstrated in a paper submitted to a meeting of its governing council in September 2017, presented by the GPhC's Head of Education. [36] It stated: *"The decision about whether a pharmacy technician has the appropriate competencies to carry out a "final" accuracy check is for the employer. They will have observed the pharmacy technician check accurately in the context in which they are working, using the standard operating procedures and other safeguards in their workplace, and they are in the appropriate position to delegate the level of responsibility of a "final accuracy check" to their staff."* [83] The statement overlooks the Responsible Pharmacist Regulations 2009, which codify that it is the pharmacist's, and not the employer's, responsibility to ensure the safe and effective running of the pharmacy and to establish standard operating procedures, maintain them and keep them under review. [84] It also overlooks pharmacists' civil and criminal liabilities in the event of a dispensing error. Of

further significance is that 49.2% of pharmacies in Great Britain are in large multiple chains with 100 or more pharmacies. [85] The owners of such pharmacies often engage non-pharmacist personnel to manage them. The directors of corporate bodies in large multiples, and many of their appointed non-pharmacist managers, are unlikely to have spent a significant amount of time observing pharmacy technicians working in practice, and with no accountability or professional credentials, may be poorly placed to make a decision underpinned by public safety considerations as to whether a pharmacy technician should conduct a final accuracy check. The decision to which the GPhC referred is for pharmacists, but the lack of understanding of pharmacy law and ethics on its part is a cause for concern.

The GPhC's lack of understanding of the nature of the final accuracy check on prescription items was further demonstrated in a draft evidence framework, intended to be used alongside its revised Standards for the Initial Education and Training of Pharmacy Technicians, introduced in October 2017 and applicable to courses from September 2018. [86] [69] The draft evidence framework was published in October 2017 and stated: "*A final accuracy check is part of a process of technical checks of medicines and other items for their accuracy, before they are dispensed.*" [87]

5.12 Conclusions

1. Pharmacy technicians need an effective leadership body if this newly-registered group is to advance its status and develop new roles at all levels. The only leadership body they have, [88] the APTUK, currently has around 6% of GPhC-registered pharmacy technicians in membership. The representative leadership bodies for dental technicians and dispensing opticians have over 30% and 90%, respectively, of registered persons in membership.

2. The APTUK is poorly resourced, its officers are not representative of pharmacy technicians as a whole and it lacks knowledge and expertise of front-line community

pharmacy practice - the sector in which the majority of its potential members practice.

3. Despite its lack of professional mandate and the fact that its executive operates on a voluntary basis, the APTUK is represented on most relevant development groups in pharmacy, especially those established by the civil service. This gives it an undue degree of influence and it may provide decision makers with an inaccurate picture of the full capabilities of pharmacy technicians generally.

4. 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. There is insufficient justification for using the noun 'professional' in reference to pharmacy technicians as a group.

5. There are some very serious decisions currently being considered by the Rebalancing Medicines Legislation and Pharmacy Regulation programme board in relation to community pharmacy skill mix and supervision, which require a real understanding of the capabilities of pharmacy technicians and a proper and robust mechanism for soliciting the views of grassroots pharmacists and pharmacy technicians. Such an approach was recommended in the Francis reports following the inquiries into the Mid Staffordshire NHS Foundation Trust. Currently, no such approach is being employed. This represents a risk to public safety which must be recognised and addressed.

6. The term 'revalidation' in reference to the GPhC's framework for completing CPD cycles, a peer discussion and a reflective account, may altogether mislead the public in respect of the level of protection afforded by the framework, each time it is used. This is particularly of concern in relation to pharmacy technicians, with only 85 pharmacy technicians out of circa 23,000 on the register completing the required

CPD, peer discussion and reflective account entries in the pilot of the GPhC's "continuing fitness to practise framework" in 2016. [16]

7. The function of the GPhC and the PSNI, as public authorities, is to protect the public through the regulation of its registrants and pharmacy premises by ensuring adherence to the necessary standards. The GPhC and the PSNI, through their positions on the Rebalancing Medicines Legislation and Pharmacy Regulation programme board's supervision working group and on the board itself, were involved in the design of proposals which if enacted would change the supervision arrangements for medicines supply in the United Kingdom – and indeed the operating framework in community pharmacy – then agreeing to keep the proposals confidential and not discuss them publicly. This raises questions about the extent to which the pharmacy regulators should be involved in the development of healthcare policy beyond that which is concerned with protecting the public by ensuring adherence to the necessary regulatory standards (this is the main objective of the GPhC as specified in article 6 of the Pharmacy Order 2010). [89]

5.13 Recommendations

1. The debate around skill mix involving pharmacists and pharmacy technicians must be led by the pharmacy profession, using a transparent process of wholesale professional engagement and not by the government, through a process involving a small and exclusive programme board, the members of which have been hand-picked by civil servants, whose activities and communications are carefully stage-managed and whose existence lacks any professional mandate.

2. Whether it is the APTUK or some other future organisation purporting to represent pharmacy technicians, it must be credible and broadly representative not just in terms of its membership numbers, but also in respect of its ability to represent all

sectors of practice. A representative mandate can only be achieved with at least 25% of pharmacy technicians on the GPhC register in membership.

3. Policy makers must recognise the serious limitations of the extent to which they can rely upon APTUK currently, when considering important policy regarding skill mix and supervision in community pharmacy. There is no organisation at present which represents a significant proportion of community-based pharmacy technicians.

4. The differences between the word professional as an adjective (*being* professional) and as a noun (being *a* professional) must be reflected in the narrative that is used when any debates around skill mix occur.

5. When any debates around skill mix occur, it must be recognised that the creation of a register of pharmacy technicians by a healthcare regulator did not and has not led to the automatic creation of a new healthcare profession.

6. The pharmacy profession must agree which bodies can most appropriately represent its views in relation to any proposed changes to national government policy which have the potential to affect it.

7. A debate must be held about the extent to which the pharmacy regulators should be involved in the development of wider healthcare policies which extend beyond those designed to protect the public by ensuring adherence to the necessary pharmacy regulatory standards.

8. Policy makers must take additional steps to establish whether pharmacy technicians working at the coalface in the community pharmacy setting are currently, or will ever be, on board with any of their proposals - for example in relation to skill mix and supervision. This could be done in a number of ways:

a. Undertaking impact assessments and encouraging pharmacy technicians and pharmacists who will be affected by the changes being considered to submit their views based upon their coalface experiences (see recommendations of the Francis inquiries into the Mid Staffordshire NHS Foundation Trust). [38] [39]

b. Creating a meaningful opportunity for those who might be concerned about the changes being considered and the policy makers considering them to have a direct exchange of views with front-line pharmacists and pharmacy technicians, in order to create proposals which are then put out for public consultation (see the recommendations of the Francis inquiries into the Mid Staffordshire NHS Foundation Trust).

c. Undertaking direct surveys of either all registered pharmacy technicians and pharmacists, or large-scale representative samples of pharmacy technicians and pharmacists, on specific subjects, when required.

Failure to do this will create the risk that the readiness of the most senior higher-echelon pharmacy technicians to undertake new roles and responsibilities may be considered by policy makers to represent the overall state of readiness of all pharmacy technicians, whatever their level of seniority and whatever their scope and sector of practice; this is not the case. The result will be the failure to secure the support of the wider population of both pharmacists and pharmacy technicians, a failure of skill mix in community pharmacy and ultimately the diminution of public care and safety.

9. The review of CPD, peer discussion and reflective account records submitted by GPhC registrants should be conducted by pharmacists.

10. The GPhC should publish a statement explaining that its "revalidation" framework will not involve the revalidation of pharmacists or pharmacy technicians. It should

revisit the framework for ensuring continuing fitness to practice applicable to both pharmacists and pharmacy technicians, with a view to creating a tailored approach appropriate for the roles and responsibilities of each registrant group. The GPhC's revalidation framework and processes should be renamed and given a title or titles consistent with the level of public protection and assurance afforded.

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