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1   **Community pharmacists in Englands' opinions on skill-mix and delegation**

2  
3   **Abstract**

4  
5   **Objectives**

6   Following the 2005 contractual framework amendment, the expanding role of community  
7   pharmacy team-members required a shift in entrenched views on roles and duties. This study  
8   aimed to report on community Pharmacists' opinions on skill-mix and explore how they can be  
9   addressed so that skill-mix may be optimised.

10  
11   **Methods**

12   An invitation to complete an online questionnaire was sent via email, marked for the attention  
13   of the lead pharmacist. Following a low response, a paper-based questionnaire was sent to all  
14   community pharmacies in England (n=11,816 Questions elicited data about the respondent, the  
15   pharmacy (including staffing profile) and opinions on skill-mix.

16  
17   **Key Findings**

18   1154 returns were received, representing a 10% response rate. Of these, most were pharmacy  
19   chains (76%; n=877), with 5-9 staff (54%; n=600); commonly open 40-49 hours (42%; n=487),  
20   dispensing <6000 prescriptions per week (41%, n=533). From 26 statements on skill-mix, 3  
21   factors were identified by principal-components factor-analysis: "working well", "feeling the  
22   pressure" and "open to development". Associated with 'working well': pharmacy owners, single  
23   businesses, with a pharmacy technician, dispensing fewer prescriptions, open shorter hours.  
24   Associated with 'feeling the pressure': pharmacy chains, open longer hours, large numbers of  
25   prescriptions, relief pharmacists. Associated with 'open to development': recently qualified,  
26   second pharmacists, working longer hours, chains, dispensing lower numbers of prescriptions.

27  
28   **Conclusions**

29   Although limited by a low response, results suggest being in a position to influence (more  
30   experienced, business owners) may be associated with more positive opinions. Further training  
31   (including about legalities and leadership) could contribute to optimising skill-mix in community  
32   pharmacies.

33 **Introduction**

34

35 In line with wider international developments in pharmacy, the role of the community  
36 pharmacist in England has expanded over the last decade with the introduction of a more  
37 clinical focus.<sup>1,2</sup> In 2005, the essential, advanced and enhanced services of the new general  
38 pharmaceutical services contract came into place.<sup>3,4</sup> This allowed pharmacists to provide  
39 services which were previously carried out by GPs, such as vaccination services ("flu jabs" or  
40 travel clinics) and assessments (e.g. cardiovascular disease risk assessments, blood pressure  
41 checking and cholesterol testing), and to delegate certain pharmacist tasks to other members  
42 of the pharmacy team.<sup>5</sup> The 2006 Health Act facilitated the development of further clinical  
43 services<sup>6</sup> and collaborative partnerships with GPs and others.<sup>7</sup> While all of the United Kingdom  
44 are governed by the same pharmacy laws, the devolved nature of each nation within leads to  
45 some national differences. For example, the Healthy Living Pharmacy (HLP) initiative in England  
46 encouraged pharmacy delivered services such as weight management, smoking cessation,  
47 alcohol awareness and medicines use reviews.<sup>8</sup>

48

49 Whilst the development of these new roles and services has increased the profile of the  
50 community pharmacy and the relationship of the pharmacist with patients, it is set against a  
51 background of an increasing dispensing service. Between 2005 and 2015 the number of  
52 dispensed prescriptions by community pharmacists in England increased by 51%.<sup>9</sup> These  
53 developments have been linked to an increased workload for community pharmacists.<sup>4</sup> One  
54 study found that 57% of pharmacists surveyed reported feeling stressed at work since the new  
55 contract, were working longer hours and had insufficient time for paperwork and other tasks.<sup>4</sup>  
56 Other studies report similar pressures: perceived patient pressure to deliver services quickly,  
57 conflicting priorities, insufficient staffing, task frustration, guilt at taking breaks, management  
58 responsibilities, profit-driven organisational cultures and frustration that heavy workloads  
59 limitability to positively impact on patients' healthcare.<sup>5, 10-12</sup> Jacobs et al<sup>13</sup> reported that  
60 pharmacists' perceived workload impacted on patient safety and their own well-being.  
61 Pharmacists reported concern that the busy, multi-tasking environment increased their risk of  
62 errors.<sup>5, 14</sup>

63

64 These developments align with a growing international interest in optimising the skill-mix  
65 within community pharmacies.<sup>2</sup> Skill-mix refers to the mix of staff and the balance of different  
66 levels of responsibility.<sup>15</sup> Role enhancement, role substitution or delegation<sup>5</sup> all affect skill-mix.  
67 Role enhancement increases the depth of a role by adding additional competencies, delegation  
68 involves allocating a task to another, either upwards or downwards in the professional  
69 hierarchy, while role substitution increases breadth by incorporating tasks from other  
70 professional roles.<sup>16</sup> In UK pharmacy, two forms of role substitution initiatives have occurred:  
71 inter-professional (where pharmacists carry out tasks previously undertaken by GPs) and intra-  
72 professional (for example where pharmacy technicians or accuracy checking technicians (ACTs)  
73 carry out tasks previously performed by pharmacists).<sup>3, 17</sup> See Table 1 for more information on  
74 pharmacy support staff roles in the UK.

75

76 Delegation of less-complex tasks to competent, but less-qualified and lower-cost professionals  
77 allows pharmacists more time to complete the interventions only they can perform.<sup>18</sup> Workload  
78 studies post-2005 highlight that community pharmacists had problems delegating to  
79 appropriate members of staff.<sup>19</sup> Despite reporting willingness to delegate parts of the  
80 dispensing process,<sup>8, 20</sup> pharmacists still carried out tasks which could be performed by  
81 pharmacy technicians or ACTs.<sup>4, 5, 8, 21-23</sup> While there is a paucity of evidence on pharmacists'  
82 views on delegation, it does suggest that although they enjoy working within a team<sup>3, 4</sup> and are  
83 happy with the extra responsibility,<sup>4</sup> they have concerns about maintaining their professional  
84 boundaries,<sup>3</sup> or accountability for delegated tasks.<sup>20</sup> However, pharmacy technicians performing  
85 substituted roles, express feelings of enhanced job satisfaction.<sup>3</sup>

86

87 For community pharmacy to continue to develop and optimise its services, it is imperative that  
88 an appropriate skill-mix is employed within the community pharmacy. The aim of this study was  
89 to gauge pharmacists' opinions on skill-mix within their pharmacy and changes that they would  
90 like to make to improve team work.

91

92

### 93 **Methods**

94

95 A questionnaire was issued to lead pharmacists in community pharmacies in England to explore  
96 their opinions on skill-mix, both within their pharmacy team and more generally. A combination  
97 of open and closed questions elicited data about the respondent and their pharmacy, their  
98 opinions to skill-mix, and the changes they would like to make to their team. Adopting a broad  
99 approach, the research team consulted two groups of pharmacists (one from England and the  
100 other Scotland) via local practice fora (LPF) meetings to clarify terminology. The team  
101 determined it useful to seek advice outside of England as well as within to help challenge use of  
102 terminology. A targeted review of literature published post-contract changes in 2005 was also  
103 used to inform the design of the questionnaire. The study's Advisory Group (which included  
104 patient and public representatives) provided critical feedback on drafts. The questionnaire was  
105 piloted with a convenience sample of 10 local community pharmacists who provided feedback  
106 at a face-to-face meeting. Extensive consultation was also carried out with representatives from  
107 major pharmacy chains. Ethical approval was gained from Cardiff University (PGMDE/30.5.14).

108

109 The questionnaire was initially developed for online distribution via Bristol Online Surveys.  
110 Distribution of the questionnaire via chain pharmacies' internal email communications was  
111 negotiated. To reach independent or small chain pharmacies, the survey was promoted on  
112 social media (Twitter) and via personal contact by members of the research team, Advisory  
113 Group and LPF contacts. Following a very low response rate, a paper version was developed  
114 and mailed, with covering letter and a pre-paid return envelope, to every community pharmacy  
115 in England listed on the GPhC database (registered January 2015) marked for the attention of  
116 the lead pharmacist. Pharmacies in hospitals, prisons and within GP surgeries/clinics were  
117 excluded. Questionnaires were sent to 11,846 community pharmacies, 30 were returned as  
118 undeliverable. No reminders were sent. Both versions of the survey asked participants to  
119 provide the first part of their postcode, this was used to check for duplicate responses.

120  
121 The survey data from the paper and online questionnaires were combined and analysed in IBM  
122 SPSS Statistics 20. Principal component factor analysis, using varimax rotation with Kaiser  
123 normalization, was applied to responses to opinion statements. Multiple regression analysis  
124 was run for each factor to predict association of respondent characteristics (e.g. respondent  
125 role, years qualified, single/chain pharmacy, number of prescriptions issued, and employing a  
126 pharmacy technician or an ACT). Open comments were coded thematically and quantified for  
127 summary.  
128  
129

## 130 **Results**

### 131 ***Respondent and pharmacy characteristics***

132 1154 returns were received (1108 paper-based; 46 online; no duplicates) representing a 10%  
133 voluntary sample. The main respondents were pharmacy managers (60%, n=60/1142) or  
134 owners (16%, n=185/1142). Most commonly respondents had been qualified for at least twenty  
135 years (39%, n=442/1148).  
136

137 Respondents were asked to provide information on their main pharmacy. Most were from  
138 pharmacy chains (76%, n=877/1153), commonly open 40-49 hours (42%, n=487/1153), and  
139 dispensing fewer than 6,000 prescriptions per month (42%, n=533/1142). The pharmacy team  
140 size was most commonly six employees (14%, n=160/1119); over half (61%, n=677/1119) had  
141 between 5-9 members of staff. Of the pharmacies employing 5-9 team members, 42%  
142 (n=216/517) included a pharmacy technician and an ACT in 24% (n=122/517). Use of a  
143 dispensing hub (7%, n=75/1136) or a robot in the pharmacy dispensing process was rare (2%,  
144 n=22/1151). Prescription delivery services were offered by 87% (n=998/1149) of the  
145 pharmacies.  
146

### 147 ***Opinions on skill-mix and delegation***

148 Participants were asked to indicate their level of agreement/disagreement with a series of  
149 statements regarding skill-mix in community pharmacy (Table 2). Over half of respondents  
150 (51%, n=591/1146) strongly agreed that they worked well as a team in their pharmacy. At least  
151 two-thirds of respondents agreed/strongly agreed with statements about good team leadership  
152 (88%, n=1016/1146, although 68%, n=778/1142, would welcome leadership training),  
153 professional trust in team-members (82%, n=948/1148) and confidence in their abilities (75%,  
154 n=871/1145), desire to see greater use of extended roles in their workplace (74%, n=846/1140)  
155 and having the right people in the right jobs in their pharmacy (69%, n=790/1139). However,  
156 over half strongly agreed that their workload (58%, n=664/1140) and the workload of their  
157 pharmacy team (56%, n=647/1146) was increasing. A notable proportion (83%, n=950/1144)  
158 agreed/strongly agreed that there should be minimum staffing levels. Of interest is the finding  
159 that 40% (n=460/1146) agreed/strongly agreed that team-members worked beyond their  
160 qualification and training.  
161

162 Principal component factor analysis (using varimax rotation) was employed to see if the 26  
163 opinion statements could be grouped to create a smaller number of variables (or factors). This  
164 analysis identified three factors (Table 3).

165  
166 Factor 1, 'working well' (15.6% variance) depicted pharmacy members working well as a team,  
167 aware of the different roles and responsibilities of team members, with skill-mix used to best  
168 advantage and sufficient staffing levels to provide services without pressure. Respondents felt  
169 able to influence both the number and the skill-mix of staff within their pharmacy. They  
170 reported having the right people in the right jobs and had professional trust and confidence in  
171 the members of their team. Resources were viewed as sufficient to improve staff skills. They  
172 felt able to offer good team leadership. Staff job satisfaction was reported to be high.  
173

174 In factor 2, 'feeling the pressure' (7.9% variance) respondents showed high agreement with  
175 statements indicating that their workload, and the workload of their team was increasing. They  
176 reported that their practices had insufficient staffing to provide pharmaceutical services and  
177 that there should be minimum staffing levels related to the amount of business. Pharmacy  
178 technician pay was thought to be unsatisfactory and did not reflect the increased  
179 responsibilities required and their career options within community pharmacy were limited.  
180

181 Factor 3, 'open to development and training' (5.03% variance) grouped statements which  
182 showed respondents felt the community pharmacy contract supported enhanced skill-mix and  
183 the provision of professional services. However, these statements also revealed a desire to see  
184 greater use of skill-mix and training in team leadership.  
185

186 Multiple regression analysis predicted association of respondent characteristics with the three  
187 factors. Respondent characteristics showing statistically significant positive association ( $p<.05$ )  
188 with the factor '*working well*' (factor 1) were pharmacy owners and those from single  
189 businesses, with a pharmacy technician, dispensing fewer prescriptions and open for shorter  
190 hours. Pharmacy chains, open for longer hours, handling large numbers of prescriptions or  
191 relief pharmacists were significantly positively associated with '*feeling the pressure*' (factor 2).  
192 Views on '*open to development and training*' (factor 3) were significantly positively associated  
193 with respondents qualified within the last five years, in a second pharmacist role, working  
194 longer hours in a chain, and dispensing lower numbers of prescriptions.  
195

### 196 ***Confidence in delegation***

197 Ninety-two percent of respondents reported confidence in delegating workload to other team  
198 members (n=990/1073). No statistically significant correlation was found between confidence  
199 delegating workload and respondent or pharmacy characteristics. From responses to an open  
200 question (n=159), confidence would increase through management support (2%, n=3) along  
201 with a relaxing of the legal responsibility for delegated work ("make ACTs fully responsible for  
202 their own mistakes. Pharmacist should be accountable only for limited check when working with  
203 an ACT." Pharmacy Manager) (9%, n=15) and more highly trained staff ("I try to delegate but  
204 they don't complete the tasks properly which needs to be redone by the pharmacist." Pharmacy

205 Manager) (25%, n=39) who are willing and able be trusted to take responsibility for tasks (16%,  
206 n=25) would enhance trust in their ability to work to professional standards. A high workload (“*I  
207 feel the team already has pressure to work to limits and fear asking more.*” Pharmacy Manager)  
208 (8%, n=12) and a lack of familiarity with the pharmacy team (locums or new staff members)  
209 (2%, n=3) negatively affected their willingness to delegate.  
210

### 211 **Desired changes to the pharmacy team**

212 An open question asked what, if anything, respondents would like to change about their  
213 pharmacy team (n=758). Desired change included recruiting new staff (38%, n=289) or staff  
214 training and development (20%, n=151) (“*We need fully trained staff. I have to train them whilst  
215 doing my job which is stressful.*” Pharmacy manager). Others commented on the need for  
216 improvement in individual team members’ motivation or professionalism (13%, n=99)  
217 (“*Attitude. People think they are working in retail and not in healthcare. Staff need to  
218 understand importance of clinical and procedural requirements.*” Pharmacy manager) and a few  
219 wished to replace underperforming staff. Respondents wanted to see better financial  
220 recognition for staff with extended roles and changes to the career pathways for pharmacy  
221 technicians and ACTs. They also highlighted regulatory constrictions.  
222

223 When asked, just under half (46%, n=513/1105) reported wanting to appoint new staff to  
224 enable them to develop or extend the skill-mix in their pharmacy while 35% (n=389/1105) did  
225 not (18%, n=203/1105, were unsure). Of those who wanted more staff, 79% (n=405/513) were  
226 from chains, and 39% (n=197/510) processed between 2,200-5,999 prescriptions. Respondents  
227 were asked to identify job-roles they would like to recruit: ACTs (70%, n=214/305), medicine  
228 counter assistants (MCAs) (65%, n=181/278), dispensing assistants (NVQ L2) (64%, n=165/259),  
229 pharmacists (61%, n=159/259), pharmacy technicians (55%, n=135/243) and pre-registration  
230 trainee pharmacists (53%, n=120/225).  
231  
232

### 233 **Discussion**

234 While responses to opinion statements reflected a positive depiction of community pharmacy  
235 skill-mix, the factor analysis identified three broad views of skill-mix in community pharmacies.  
236 There were respondents identifying teams that were working well; ‘right’ people in the ‘right’  
237 roles, with a pharmacist with good knowledge of the roles and confidence in their team, with  
238 sufficient resources for training and the ability to influence their staffing and skill-mix. Another  
239 pattern represented community pharmacists feeling the pressure of their increasing workloads;  
240 insufficient staffing and no influence over staffing decisions, recognising poor career prospects  
241 or financial reward for team members who extend their role. A third group were satisfied with  
242 the current contract but welcomed training in leadership and would like to see greater use of  
243 skill-mix. The present study also adds a level of detail that sheds light on how practice factors  
244 influence how skill-mix is viewed and operationalised. Skill-mix was more likely to be perceived  
245 as working well by pharmacy owners and those from single businesses, dispensing fewer  
246 prescriptions, open for shorter hours and those employing pharmacy technicians. In contrast,  
247 workload pressures seemed to be felt more acutely by those in pharmacy chains, open for

248 longer hours, handling large numbers of prescriptions and by pharmacists in a manager, rather  
249 than owner position. Second pharmacists, fewer years qualified, working longer hours,  
250 dispensing fewer prescriptions in a chain were associated with the factor identifying “open to  
251 development”. While confident about their ability to delegate, many respondents still valued  
252 further leadership training.

253  
254 Our study has limitations, most notably difficulties were experienced in generating a higher  
255 response rate to the questionnaire. After lengthy, in-depth consultation with several large UK  
256 chains we trusted them to disseminate the information to their pharmacies but we have no way  
257 of knowing how many received and read the email. More thorough piloting of this method  
258 would have identified and avoided these issues. A mailed paper copy proved notably more  
259 successful but owing to time and budgetary limitations we were unable to send a reminder.  
260 Targeting a smaller, representative sample (e.g. a sample of pharmacies with and without a  
261 Pharmacy Technician) and sending reminders may have improved our response rate. While the  
262 sample was diverse (single businesses/chains; managers/owners), the findings arising from the  
263 survey must be interpreted in light of the low response rate. Additionally, we did not  
264 determine the tasks that each team member carries out within their pharmacy, future research  
265 would benefit from establishing how the skill-mix was being implemented.

266  
267 Those with higher workload and working longer hours were feeling the pressure. Staffing levels  
268 insufficient for their heavy workload and preventing time to train up current team members  
269 was identified by some; reflecting the literature<sup>8, 24, 27, 29, 30, 35, 36</sup>. A high number of pharmacy  
270 support roles were part-time. This can lead to communication issues, and leaves the pharmacy  
271 in a precarious position if unexpectedly short-staffed (e.g. sickness leave); this may result in  
272 tasks being partially delegated, if at all.<sup>36</sup> Our results also suggested that power over staffing or  
273 skill-mix were influencing factors in whether respondents’ viewed skill-mix positively or  
274 negatively. Jacobs et al<sup>13</sup> also found links between areas of self-reported pharmacist stress,  
275 increasing workload, and little autonomy.

276  
277 Less qualified roles were viewed positively and seen as easing workloads and releasing  
278 pharmacist time for services and greater patient contact. For example, respondents noted that  
279 MCAs were the public-facing first-line of pharmacy for patients, able to deal with enquiries and  
280 reducing interruptions to dispensing assistants or pharmacists, a noted source of workplace  
281 stress.<sup>13</sup> DAs were requested to carry out the less complex work within the dispensing process  
282 to free up pharmacists and ACTs. MCAs and DAs are also the largest group of community  
283 pharmacy support staff.<sup>15</sup> These findings may also, in part, be influenced by familiarity with the  
284 roles or responses which raised questions about support staff’s scope of practice.

285  
286 While a high proportion had confidence in their staff and trust in their work, respondents also  
287 identified staff professionalism as an area for improvement— some reported that staff still view  
288 it as a retail job rather than healthcare and others had staff uninterested in training to extend  
289 their role. Staff members unwilling to train or take on new tasks impact the development and  
290 workflow of skill-mix.<sup>8, 11, 15, 25, 28</sup> A New Zealand study found pharmacy assistants gave mixed  
291 responses when asked if they were healthcare assistants or retail assistants.<sup>37</sup> A UK-based study

292 found that the location and hours of the job were almost as frequent a reason for applying for  
293 the role as a desire to work in healthcare.<sup>15</sup> Like some other countries (e.g. Canada, Denmark,  
294 South Africa) certain roles within the pharmacy team are regulated professions.<sup>2</sup> Mandatory  
295 registration and associated requirements of some roles (e.g. pharmacy technicians, ACTs) may  
296 also deter some staff from developing their role. Limited opportunities for career progression  
297 and unsatisfactory levels of financial reward for the additional responsibility were also  
298 recognized in our results.

299

### 300 **Conclusions**

301 Although limited by a low response rate, the sample was diverse and circumstances and  
302 opinions differ. By revealing how practice factors influence the way in which skill-mix is viewed  
303 our study makes a novel contribution to the literature. We highlight the cycle that some  
304 community pharmacies find themselves in where skill-mix has the potential to ease workload  
305 and enhance service provision, particularly in larger, busy pharmacies, but pharmacists' lack the  
306 time, or influence to implement the necessary changes. The results suggest that being in a  
307 position to influence (more experienced, business owners in single pharmacies) may make a  
308 difference to opinions. Patient-facing and dispensing staff were highly valued alongside more  
309 technical roles as a way to lessen pharmacists' workload. However such team members'  
310 motivation and understanding of their role may not always match expectations. This highlights  
311 the importance of the whole team culture in community pharmacy and the pharmacists' role as  
312 motivational team leader.

313

314

315

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Table 1: Roles and responsibilities of pharmacy support staff

Job	Role	Skill/Qualification
Medicine Counter Assistant (MCA)	A medicine counter assistant (MCA) is involved in the sale of over-the-counter medicine and works under the supervision of a pharmacist. A MCA is trained to offer advice on common ailments and must know when to refer a customer to a pharmacist.	Medicines counter assistants must complete an accredited medicines counter assistant course.  The programme is taught at Qualifications Credit Framework level 2
Dispensing Assistant	A dispensing assistant is involved in: <ul style="list-style-type: none"> <li>• The provision of information to customers on symptoms and products</li> <li>• Prescription receipt and collection</li> <li>• Assembly of prescribed items (including the generation of labels)</li> <li>• Ordering, receiving and storing of pharmaceutical stock</li> <li>• Preparation for the manufacture of pharmaceutical products</li> <li>• Manufacture and assembly of medicinal products</li> </ul>	Dispensing assistant must complete a level 2 knowledge and competency-based dispensing assistant qualification. . •
Technician	Technicians prepare medicines and other healthcare products and supply them to patients. They also take an active role in providing patients with guidance on taking medicines. The role may also include training and development, and supervision and management of staff and the dispensary. <ul style="list-style-type: none"> <li>•</li> </ul>	The training consists of two years consecutive work-based experience under the direction of a pharmacist to whom the trainee is directly accountable.  The training programme must be approved by GPhC and meet the requirements below: <ul style="list-style-type: none"> <li>• Level 3 Diploma in Pharmaceutical Science (Knowledge)</li> <li>• Level 3 NVQ Diploma in Pharmacy Services Skills (Competence)</li> </ul> Once the course is successfully completed technicians are required to register with GPhC before they can practice as a Pharmacy technician.
Accuracy checker	The accuracy checker is able to confirm the dispensing accuracy of any prescription that has been clinically screened/approved by a registered pharmacist.	Within the UK there is a recognised competency framework for the accuracy checker training programme, but there is no requirement for programmes to be aligned to the framework.  The range of skills and knowledge which may be covered within a programme are: checking accuracy skills, effective

*communication skills, team working skills,  
legal considerations, dispensing and  
medication errors.*

*ACTs are GPhC registered professionals.*

Table 2: Opinions on skill-mix within their pharmacy

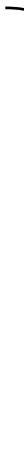
Statements (n=valid number)	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
We work well as a team in this pharmacy (n=1146)	1 (7)	1 (16)	4 (43)	42 (489)	51(591)
My workload is increasing (n=1140)	1 (7)	21 (17)	5 (61)	34 (391)	58(664)
The workload of the pharmacy team is increasing (n=1146)	0 (5)	3 (32)	6 (65)	34 (397)	56(647)
I feel I am able to offer good team leadership (n=1136)	0 (4)	2 (18)	9(98)	59(684)	29(332)
There should be minimum staffing levels related to the amount of business (n=1144)	3 (31)	5 (55)	9 (108)	43 (493)	40 (457)
I have professional trust in the other members of staff in this pharmacy (n=1148)	1 (9)	5(54)	12 (137)	58 (670)	24(278)
I have confidence in the abilities of all members of this pharmacy team (n=1145)	1 (14)	10 (114)	13 (146)	49 (567)	26(304)
I would like to see greater use of extended roles and responsibilities in my workplace (n=1140)	1 (13)	4 (44)	21 (237)	53 (607)	21 (239)
We have the right people in the right jobs at this pharmacy (n=1139)	2 (18)	14 (157)	15 (174)	50 (571)	19 (219)
I would welcome training in team leadership (n=1142)	3 (30)	9 (104)	20 (230)	45 (514)	23 (264)
The community pharmacy contract encourages pharmacies to supply professional services (n=1145)	6 (66)	15(166)	18 (206)	48 (547)	14 (160)
The skill-mix in this pharmacy is being used to best advantage (n=1140)	2 (23)	15(174)	21 (239)	49 (539)	12 (141)
I am able to influence the skill-mix required for this pharmacy (n=1139)	8 (87)	17 (195)	18(202)	40 (454)	18 (201)
Career prospects for pharmacy technicians in community pharmacy are limited (n=1143)	4(41)	18 (203)	24 (277)	39(450)	15 (172)
Compared to dispensers, the financial reward is not great enough for the increased responsibilities of the pharmacy technician (n=1120)	3 (33)	15(174)	30 (343)	35 (399)	15(171)
Job satisfaction levels of staff in this pharmacy are high (n=1138)	7(74)	20 (226)	27 (310)	37(430)	9(98)

I am able to influence the number of staff required for this pharmacy (n=1146)	19 (215)	24(275)	12 (138)	27 (306)	19 (212)
Sufficient resources are available to improve staff skills (n=1141)	7 (82)	23(265)	23 (277267)	39 (440)	8(87)
I think the registration requirements deter staff from developing into the registered pharmacy technician role (n=1141)	7 (81)	26 (299)	28(315)	31 (353)	8(93)
There are members of this team who are working beyond their qualification and training levels (n=1146)	10 (112)	30(349)	20 (225)	27(306)	13 (154)
The staff level in this pharmacy is sufficient to provide pharmaceutical services without pressure (n=1142)	15 (170)	31 (353)	16 (188)	30 (342)	8 (89)
The community pharmacy contract supports enhanced skill-mix (n=1140)	9(103)	22 (249)	35(393)	30(336)	5 (59)
The pay for pharmacy technicians is satisfactory (n=1136)	7 (84)	24(276)	37(423)	27(300)	5 (53)
I am unsure of the legalities of pharmacy technicians' scope of practice (n=1141)	13 (144)	34 (393)	28 (319)	22 (246)	4(40)
Staff turn-over is high in this pharmacy (n=1134)	35(401)	34 (382)	15 (171)	11(121)	5 (59)
I am not quite sure of the roles and responsibilities of different members of the team (n=1147)	48 (550)	40 (453)	7 (84)	4 (48)	1 (12)

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409      *Table 3: Results of factor analysis and summary of statistically significant relationships between responses and*  
 410    *pharmacy or respondent characteristics*

Factor	Significant relationships
<b>1. <u>Working well(15.59% variance)</u></b> <ul style="list-style-type: none"> <li>• We work well as a team in this pharmacy</li> <li>• We have the right people in the right jobs at this pharmacy</li> <li>• I am able to influence the number of staff required for this pharmacy</li> <li>• I feel I am able to offer good team leadership</li> <li>• I have confidence in the abilities of all members of this pharmacy team</li> <li>• The staff level in this pharmacy is sufficient to provide pharmaceutical services without pressure</li> <li>• I am not quite sure of the roles and responsibilities of different members of the team(INVERTED)</li> <li>• Job satisfaction levels of staff in this pharmacy are high</li> <li>• I have professional trust in the other members of staff in this pharmacy</li> <li>• I am able to influence the skill-mix required for this pharmacy</li> <li>• The skill-mix in this pharmacy is being used to best advantage</li> <li>• Sufficient resources are available to improve staff skills</li> </ul>	 <ul style="list-style-type: none"> <li>• Open regular hours</li> <li>• Fewer prescriptions</li> <li>• Single businesses</li> <li>• Pharmacy owners</li> </ul>
<b>2. <u>Feeling the pressure (7.860% variance)</u></b> <ul style="list-style-type: none"> <li>• Compared to dispensers, the financial reward is not great enough for the increased responsibilities of the pharmacy technician</li> <li>• My workload is increasing</li> <li>• The staff level in this pharmacy is sufficient to provide pharmaceutical services without pressure (INVERTED)</li> <li>• Career prospects for pharmacy technicians in community pharmacy are limited</li> <li>• There should be minimum staffing levels related to the amount of business</li> <li>• The workload of the pharmacy team is increasing</li> <li>• The pay for pharmacy technicians is satisfactory (INVERTED)</li> <li>• I am able to influence the number of staff required for this pharmacy (INVERTED)</li> </ul>	 <ul style="list-style-type: none"> <li>• Open longer hours</li> <li>• Larger numbers of prescriptions</li> <li>• Chains</li> <li>• Relief pharmacists</li> </ul>
<b>3. <u>Open to development &amp; training (5.032% variance)</u></b> <ul style="list-style-type: none"> <li>• The community pharmacy contract supports enhanced skill-mix</li> <li>• The community pharmacy contract encourages pharmacies to supply professional services</li> <li>• I would welcome training in team leadership</li> <li>• I would like to see greater use of extended roles and responsibilities in my workplace</li> </ul>	 <ul style="list-style-type: none"> <li>• Open longer hours</li> <li>• Fewer prescriptions</li> <li>• More recently qualified</li> <li>• Chains</li> <li>• Second pharmacists</li> </ul>

412      KMO .810, Bartlett's Test of Sphericity p>0.001, all values were above the Measure of Sampling Adequacy level of  
 413    0.5.

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