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Support staff in community pharmacy: who are they and what do they want?

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Abstract

Objective To collect information on different categories of support staff, their deployment in community pharmacy, their levels of experience and qualifications, and their opinions on a number of topical issues, such as training and regulation.

Method Two 'snapshot' surveys, one of community pharmacists, another of support staff employed by them. Three focus groups with support staff.

Setting The surveys were conducted in community pharmacies in two primary care trusts (PCTs) in England. Two focus groups were conducted in one of the PCTs with respondents who had taken part in the survey; a third took place in a third PCT during the design phase.

Key findings Medicines counter assistants (MCAs) formed the largest category of support staff (56%); 21% were dispensing assistants (DAs); 17% were pharmacy technicians (PTs). All community pharmacies employed at least one (60%), and often more than one MCA, but 20% had no DAs and 40% operated without a PT. Nearly all (93%) support staff were women, and about one-third worked part-time. More mature (40+ years) staff commonly only held an MCA qualification and were often not keen on further training. Younger staff held higher qualifications and were interested in further training and career progression. The majority of all categories of staff showed high levels of job satisfaction and loyalty to their employer. Most held positive views towards the regulation of support staff. Poor salaries were identified as potential barriers to further training and regulation, and pharmacists identified problems recruiting support staff.

Conclusion Many different categories of support staff are employed in community pharmacies, although some operated without DAs or a PT. Support staff were generally satisfied with their jobs, but increasing requirements for formal qualifications and regulation of support staff, if not accompanied by adequate recognition and remuneration, may worsen recruitment problems.

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Introduction

Community pharmacies play an increasingly important role in the delivery of, and access to, primary care services in the UK.[1,2] They now provide a greater range of services than they have done in the past, and many offer treatment for minor ailments, diagnostic testing and smoking-cessation programmes. Pharmacy support staff play an integral role in the delivery of primary care, and are often the first (and commonly the only) contact community pharmacy customers make when collecting prescriptions, seeking advice or purchasing over-the-counter (OTC) medicines.[3] They also play an important role in supporting the pharmacist in their dispensing and checking roles, thus freeing up time for pharmacists to spend on clinical tasks.[4,5]

This mix of staff and different levels of responsibilities is commonly referred to as a 'skill mix'. The concept refers to the balance between trained and untrained, qualified and unqualified, and supervisory and operative staff within a service area as well as between staff groups.[6] In other words, 'skill mix is about having the right grades of staff with the right levels of competence to complete all the required tasks in the working environment'.[7] Indeed, the Department of Health document *Pharmacy Workforce in the New NHS* refers to skill mix and a need to 'liberate the talent and skills of all the workforce so that every patient gets the right care in the right place at the right time'.[2]

Training, experience, qualifications, ability and teamwork will all contribute to the skills held by individuals and a disciplinary group.[8] Nevertheless, there is a paucity of research

data on support staff in community pharmacies in the UK. Existing research tends to be relatively small scale and often qualitative in nature. Much of it has focused on the role of medicines counter assistants (MCAs) in providing advice to patients about the purchase of appropriate OTC medicines.[9–11] Other studies have explored the impact of pharmacy technicians (PTs) on pharmacists' workload.[4,5] One further study explored and defined the roles of dispensary support staff,[12] the publication of which informed the now agreed (and previously lacking) definitions of pharmacy support staff (Table 1).[13] These are used to define support staff throughout this paper.

The regulation of MCAs was introduced in 1996 and regulation for the remainder of support staff came into effect in January 2005. Registration for PTs with the Royal Pharmaceutical Society of Great Britain (RPSGB) is currently only voluntary, and there is no register for MCAs or dispensing assistants (DAs). It is therefore difficult to ascertain the number of support staff employed in community pharmacy with any degree of accuracy. Estimates for 2003 from the RPSGB suggest that there are approximately 8500 PTs working in community pharmacy, and 22 500 DAs.[14] By October 1, 2007, 6196 PTs had registered with the society.[15] It is predicted that the final register, when it becomes mandatory, will contain in the region of 16 000 names, with about 69% of those registered working in community pharmacy.[16]

Besides the lack of a register, the paucity of this information can be attributed to several factors. First, pharmacy support staff are geographically dispersed, making them relatively difficult to reach. Second, commercial businesses rather than the NHS employ them, and employers are often reluctant to divulge information that they perceive to be sensitive in nature, especially details about staffing and operational issues.

In 2003, the Department of Health commissioned a study on support staff in community pharmacy. The aim was to collect information on support staff, develop a demographic profile of this group and their deployment, obtain data on the background, education and pharmacy qualifications among different categories of staff, and explore their training and career aspirations. The study also examined the views of support staff on a range of issues, including training, regulation and continuing professional development (CPD), and this paper reports its findings.

Method

The research study used quantitative and qualitative techniques to collect relevant data. The quantitative component involved two 'snapshot' surveys, one among pharmacists and a second one among pharmacy support staff. The qualitative component consisted of three focus groups with support staff.

Setting: description of study primary care trusts

For the main component of this study two primary care trusts (PCTs) were selected purposively as contrasting examples of urban and rural PCTs. They were in two geographically different locations, to account for regional differences that may exist in the recruitment and retention patterns of support staff. PCT1 was in the north of England in a relatively small yet high-density area which included large, busy, city-centre pharmacies in areas that are among the most impoverished parts of the city. PCT2 was in the south east of England and covered a relatively large area and included pharmacies operating in small market towns.

A third PCT (PCT3) was involved in the design phase of this project. It was located in the north west of England and was chosen, besides its proximity to the investigators' base, due to its mix of rural to inner-city pharmacies in a variety of deprived to relatively affluent areas. Here, community pharmacies which had been involved in previous research conducted by a member of the research team (EIS) and expressed an interest in further study participation were approached.

Focus groups, questionnaire design and survey

Over 20 support staff from a number of different pharmacies were invited to participate; only five from one independent pharmacy in PCT3 eventually participated in the first focus group. This was conducted in Autumn 2003 and its findings informed the design of the questionnaire for support staff. This explored types of support staff, demographics, data on qualifications, training and experience in community pharmacies. It also sought their views on career issues of support staff and their regulation.

A second questionnaire was designed for pharmacists which, due to the availability of documented and anecdotal evidence from pharmacists about the issues under investigation,

Table 1 Pharmacy support staff definitions[13]

Staff type	Definition
Medicines counter assistant (MCA)	A person who has satisfactorily completed or is undertaking an accredited programme of training for work in support of the sale of non-prescription medicines, the receipt of prescriptions, the handing out of completed dispensed items and the provision of advice on health matters
Dispensing assistant (DA) (other common terms: dispenser, pharmacy assistant, assistant technical officer)	A person involved in a range of pharmacy support activities covered by the 2005 minimum competence requirements
Pharmacy technician (PT)	A person who holds a Pharmacy Services Scottish/National Vocational Qualification (S/NVQ) level 3 qualification or a qualification that has been previously recognised by employers as a valid qualification for pharmacy technicians

did not require preliminary qualitative work. It collected factual information about the pharmacy, such as opening hours, number and type of support staff and issues around the recruitment.

Both questionnaires were piloted with pharmacists and support staff in three pharmacies in PCT3 in November 2003. This highlighted problems with accurately capturing the tasks performed by different categories of support staff, as well as subtle distinctions between these tasks and related responsibilities for different members of staff. It was therefore decided to omit these questions from the questionnaire and explore these issues more appropriately through two further focus groups. These were conducted in July 2004 with seven and eight female support staff in PCT1 who had responded to the main questionnaire. They covered issues around regulation, requirements for formal qualifications and barriers to training.

As there is no sampling frame (i.e. a list containing names and contact details of support staff employed in community pharmacies), all 39 community pharmacies in the two PCTs (24 in PCT1 and 15 in PCT2) were approached regarding study participation. Questionnaires were distributed to all of the community pharmacies who agreed to participate. One pharmacist and all the support staff working in each pharmacy on a particular day were asked to complete questionnaires. If there was more than one pharmacist working on the day, the pharmacy manager or the pharmacist responsible for the recruitment and employment of staff was asked to respond. In some cases, long-term locums responded, whereas some short-term locums did not feel they had sufficient information to participate.

The manner in which questionnaires were administered differed in the two PCTs. In PCT1 they were administered over a period of two days in May 2004, by way of face-to-face interviews by four trained researchers. In PCT2, questionnaires were distributed for self-completion on one day in June 2004 and subsequently returned by post. Questionnaire responses were coded and entered into SPSS for analysis. Qualitative data were analysed by examining the main themes that emerged.

Results

This section presents quantitative analysis from the surveys with pharmacists and pharmacy support staff. Where appropriate, focus group data are used to support and illustrate quantitative findings.

Survey responses

Of the 24 and 15 community pharmacies in PCT1 and PCT2, 21 and 9 consented respectively. Staff in 20 community pharmacies in PCT1 and 8 in PCT2 actually participated, thus achieving a combined response rate of 71.8%. Eighty-six support staff, and 25 pharmacists (19 in PCT1 and 6 in PCT2) completed their respective questionnaires. Because there were very few statistically significant differences between responses from the two PCTs, data were generally combined to increase statistical power.

Analysis of pharmacist questionnaires

The majority of community pharmacies were located in urban or suburban areas (n = 18; 72%). Five of the pharmacies operated from town or city centres (20%) and two operated from rural areas (8%). The rural pharmacies were both located in PCT2, whereas the majority of pharmacies in PCT1 were in urban or suburban locations. The majority (72%) of pharmacies in both PCTs had dispensing volumes of over 5000 prescription items per month.

Seventeen (68%) of the responding pharmacies belonged to one of the large multiples, 15 of them being located in PCT1. Both PCTs had three independent pharmacies each, and one in each formed part of a small chain (between two and four pharmacies). Pharmacists stated that their community pharmacies were open between 34 and 91 hours each week; just under half were open more than 46 hours per week.

Deployment of support staff

Pharmacists were questioned about the different categories of support staff they employed, and Table 2 shows their responses.

All the community pharmacies in this study employed support staff. MCAs were the largest category of support staff, and all pharmacies employed at least one but commonly more than one. Only five (20%) pharmacies operated without DAs, most employing at least one. The majority of pharmacies either had one (44%) or no (40%) PTs.

Support staff shortages

Pharmacists were asked about their experience of recruiting support staff. Some pharmacists had never needed to recruit, and some working for chains said that recruitment was done by the head/regional offices, so not all responded to this question. Nevertheless, pharmacists that had experience recruiting staff provided useful insights. Pharmacists were more likely to have experience recruiting MCAs than other categories of staff. A larger proportion had greater difficulties in recruiting DAs and PTs than MCAs, and particular problems were experienced when recruiting trained staff (Table 3).

Pharmacists were also asked what they thought the main reasons were for these recruitment difficulties, and poor salaries were the most consistent explanation attributed to the problems of recruiting DAs and PTs. Pharmacists said that salaries in community pharmacy compared unfavourably to hospital pharmacy.

Table 2 Categories of support staff employed by community pharmacies in the two study PCTs

	MCA		DA		PT	
	n	%	n	%	n	%
None	0	0	5	20	10	40
1	5	20	10	40	11	44
2–4	15	60	8	32	3	12
5+	5	20	2	8	1	4
Total	25	100	25	100	25	100

Table 3 Pharmacists' experience of recruiting support staff

	MCA (n)		DA (n)		PT (n)
	Untrained	Trained	Untrained	Trained	Trained
Never needed to	8	10	13	13	16
Never had problems	7	3	3	1	1
Experienced problems	10	7	7	8	6

In response to a shortage of support staff, employers appeared to focus their efforts on recruiting inexperienced staff, and supporting their training and development. The trend was to recruit inexperienced staff to work as MCAs and train them gradually, allowing them to gain some practical work experience and enrol for MCA training. Staff who demonstrate an interest and the potential for further training can enrol for a dispensary qualification, by which stage they are familiar with the company culture and dispensary work, and the systems that operate in the pharmacy.

Pharmacists were asked about what factors they considered when recruiting support staff, and their responses are summarised in Table 4. Personal qualities ranked much higher than other factors, particularly for MCAs. The importance of personal qualities was followed by GCSE qualifications and previous community pharmacy experience, which appeared most important when recruiting PTs. Notably, an interest in health was only mentioned by some pharmacists as being important.

Analysis of support staff questionnaire responses

The following sections report findings from the support staff survey, which are illuminated by quotes from the three focus groups where appropriate and useful.

Demographics of support staff

White women predominated amongst support staff respondents. Of the 86 respondents, only six were men and one was non-white. Respondents ranged from 17 to 64 years of age, with a mean age of 40 years; the largest proportion (37%) of support staff was 40–49 years.

Table 4 Factors pharmacists consider when recruiting support staff

	MCA (n)	DA (n)	PT (n)
Personal qualities	13	9	8
GCSE qualifications	4	4	5
Previous community pharmacy experience	3	4	6
Enthusiasm	2	1	2
Interest in health	1	3	1
Maturity		1	1

Support staff respondents worked between 2 and 45 hours per week. A relatively large proportion of them were part-time employees, one-third working less than 30 hours per week. Even though the result was not statistically significant, there was a trend for staff with a dispensary qualification to work longer hours than MCAs. With the exception of one, all support staff had permanent contracts of employment.

Support staff had relatively low levels of formal education (defined as non-pharmacy education obtained through school, tertiary or further education); nine out of ten had only completed secondary school. Further, a relatively large proportion (33%) did not have a background in mathematics or science (chemistry, physics, biology, general science) prior to working as pharmacy support staff, both of which are useful preparation for working in a community pharmacy. There was a correlation between age and studying science, where younger respondents (39 years or younger) were significantly more likely to have studied science subjects than those aged 40+ years (58% and 42% respectively; $P < 0.001$).

Reasons for joining, and satisfaction with support staff role

Although some respondents were attracted to community pharmacy because it offered interesting and challenging work (44%), almost as many (38%) said that the appeal lay in the convenience of the job, rather than the nature of the work. These figures were consistent with accounts given by support staff in the focus groups, where locality and hours of work appeared to influence perceptions of convenience, which is illustrated by a quote from one focus group participant: "What attracted me to the job was that it was just around the corner from my home, but I enjoy it so much that I wouldn't leave now".

Some older focus group participants explained that they had not actively sought a career in community pharmacy, but had heard about a vacancy and thought it offered a convenient opportunity to earn some extra income. Participants with previous retail experience had assumed that this would be useful, and several acknowledged that they had underestimated the health component of the work. In contrast, some of the younger participants in the focus groups said that part of the appeal of community pharmacy was the opportunities for further training. Although many of the respondents had not actively sought a career in pharmacy, they demonstrated high levels of commitment to, and enjoyment of, their work and customers. One focus group participant said: "the money's bad, but you love the job and that's why you do it". Some explained that this had developed as they had gained experience, which is illustrated by one participant who explained that when they started "it was just a job, but gradually it has become a vocation".

Using a drop-down list, support staff were asked which factors might influence them to change jobs, and poor salary was the factor most frequently mentioned (n = 53). Staff felt that salaries did not reflect the training received, or responsibilities held, by staff. The next two most frequently mentioned factors were less-stressful work (n = 21) and an entirely different kind of work (n = 21). Further reasons were different working hours (n = 18) and locality (n = 9). Only five respondents wanted more responsibilities, and fewer still

(n = 2) wanted less responsibility. Two support staff said they intended to move into hospital pharmacy within the next five years.

Pharmacy qualifications

Support staff were asked about their formal pharmacy qualifications. Five respondents did not have any pharmacy qualifications (or did not answer this question in the case of self-completion questionnaires). The majority of respondents had an MCA qualification (n = 48; 56%), and the National Pharmaceutical Association (NPA) qualification was the most popular one, with 40% of MCAs having obtained this. Eighteen (21%) respondents were qualified DAs, and 15 (17%) were PTs.

Respondents with an MCA qualification tended to be slightly older (mean age of 43 years), compared to an age of 37 years among those with a dispensary qualification. Respondents who had studied science at school were significantly more likely to have obtained a dispensary qualification (79%) than respondents without any science subjects (22%) ($P < 0.001$).

Respondents were also asked about their intention for further training. Nearly half (46%) of respondents said they intended to pursue further pharmacy qualifications. Among those who wanted to pursue further training, 73% of those aged 39 years and under did, compared to only 27% of those aged 40+ years ($P < 0.001$).

Many of the support staff respondents had several years' experience working in community pharmacy. Table 5 shows the periods they had been in their current post as well as their total experience in community pharmacy.

The majority of respondents had been in their current position for between one and five years (38%); almost one-third (29%) had been in post for 10 years or more. Twenty-six respondents (43%) had experience of working in another community pharmacy. Respondents with experience of working in more than one pharmacy were significantly more likely to have a dispensary qualification (58%), compared to 42% ($P = 0.018$) among those who had only worked in one community pharmacy. This suggests that skills gained in one pharmacy are recognised and transferable to others, and that staff with a dispensary qualification are in demand. Further, the majority of support staff intended to stay with their current employers in the medium term: 43% expected to be in the same position in five years' time. A further 33% hoped to occupy a more-senior position in the same pharmacy. This suggests that many pharmacy support staff remain working within community pharmacy, often in one particular one, for many years, and are happy doing so. They intend to stay and one focus group participant illustrated this by saying: "I like to think it's somewhere I'm going to stay and progress".

Table 6 shows how long respondents intended to stay at their current position. Older respondents (40+ years) were significantly more likely to say they intended to stay for the next 5 years or more (73%) than those who were aged 39 years or less (27%; $P = 0.001$).

Views on regulation of support staff and continuing professional development

Following a definition of 'regulation', which was read out to respondents, they were asked what they thought about the regulation of support staff, and the overwhelming majority (94%) were in favour. Respondents were then presented with lists of possible advantages and disadvantages of regulation, which they could choose from (as many as they wanted, therefore percentages not adding up to 100). The results can be found in Table 7.

Respondents felt that potential advantages outweighed disadvantages. The most frequently mentioned (74%) advantage was that customers would receive a better standard of service. Fifty-nine per cent reinforced this by stating that regulation would ensure the delivery of consistent levels of service. Several respondents agreed that regulation may offer support staff benefits, such as giving them more recognition (59%) or more responsibilities (56%), or enabling them to move up the career ladder (53%). However, only 37%

Table 5 Length of experience of support stafft in community pharmacy

	Current pharmacy		Total experience	
	n	%	n	%
One year or less	15	18	10	11
More than 1 year but less than 5	33	38	28	33
More than 5 years but less than 10	13	15	11	13
More than 10 years	25	29	37	43
Total	86	100	86	100

Table 6 Length of intended stay in current position

	Up to 1 year		1–5 years		5+ years (rest of career)	
	n	%	n	%	n	%
< 39 yrs	8	89	9	47	15	27
40+ yrs	1	11	10	53	41	73

Table 7 Advantages and disadvantages of regulating community pharmacy support staff

Advantages	n	%	Disadvantages	n	%
Customers get better standard service	64	74	More work/ same money	43	50
It will give support staff more recognition	51	59	Staff don't want to be trained	38	44
Consistent levels of service	51	59	CP won't pay staff more money	34	40
Staff will be given more responsibilities	49	56	CP won't be able to recruit staff	28	33
Staff move up the career ladder	46	53	Experienced staff will leave	17	20
Staff will earn better salaries	32	37	It will be expensive	15	17
It will help with workplace planning	30	34	No disadvantages	6	7

thought that regulation would enable staff to earn higher salaries. Indeed, 50% thought that regulation would mean that staff would receive extra work without any financial rewards (the most commonly mentioned disadvantage). Many respondents (44%) mentioned that some support staff would resist training, and that experienced staff would leave (20%).

The focus groups also supported these statements in the context of discussing further training. Participants felt strongly that, if they did successfully complete such training and consequently extended their roles, they should be given recognition for this. Nevertheless, although some support staff said they were happy to assume additional tasks, they were not necessarily prepared to accept greater levels of responsibility or work with lower levels of supervision. Many felt this would be an abdication of the pharmacists' responsibility.

Discussion in the focus groups further revealed very low levels of awareness and knowledge of regulation among support staff. Furthermore, most participants were unaware that CPD was a requirement of regulation. The PTs that had registered with the society did not fully understand the implications of registration and just spoke about belonging to a register, enabling them to work as locum technicians. This suggests that professional responsibility, accountability and revalidation had not been understood or embraced by many support staff.

Indeed, when respondents were asked how important they thought CPD was for support staff, more than half (58%) thought it was very important, and 38% thought it was important. Nevertheless, only 17 (20%) had undertaken some form of CPD. When asked what may prevent them from taking part in CPD, 51 (60%) mentioned lack of time, and 21 (24%) mentioned they would need to travel too far to attend continuing education events. Fifteen (17%) selected the fact that there were no financial rewards as an obstacle.

Discussion

This study took place in 2004, i.e. the year before regulation for DAs and PTs and voluntary registration for the latter came into force. Nevertheless, it provides useful insights, not only into the types of support staff employed in community pharmacy, but also into their formal qualifications, experience and informal 'on-the-job' training. It also provides insights into support staff views on their roles and responsibilities, training and regulation, which is particularly timely. Nevertheless, the results of this study are based on a relatively small sample drawn from just two PCTs. Further studies are needed to confirm whether the findings are generalisable to a wider sample or nationally.

To address its aims and objectives, this study used a number of approaches, i.e. focus groups with support staff and two surveys, one of pharmacists, the other of the support staff employed by them. The findings support anecdotal information that there are large numbers of support staff working in community pharmacies. Nevertheless, some pharmacies operated without DAs or PTs. Many support staff had considerable experience, which is not always reflected in the accredited pharmacy qualifications they possess.[17] Indeed, many of the support staff respondents were long and loyal members of staff, who were satisfied with their jobs and generally intended to remain with their current employers.

The community pharmacies in this study employed a combination of MCAs, DAs and PTs, the vast majority of them being female and about one-third of them working part-time. MCAs were the most commonly employed category of staff. There appeared to be two distinct groups of support staff. The first comprised mature women with few formal qualifications and no background in science. They did not necessarily plan a career in community pharmacy and were less likely to have obtained a dispensary qualification or, indeed, did not want to undertake any further training. The second group were younger support staff, often with some background in science, who had often obtained a dispensary qualification (DA or PT) and were attracted by the opportunities for further training, formal qualifications and career progression.

This study also addressed the views of pharmacy support staff on regulation, which proved particularly interesting and topical. Such regulation was introduced for DAs and PTs in January 2005, and the Royal Pharmaceutical Society is moving towards making the registration of PTs with the society a requirement. It was thus encouraging that the majority of support staff in this study were supportive of regulation. They felt it would offer benefits for both patients (in terms of the service delivered to them) and the staff themselves (more recognition and responsibilities). However, some registered PTs in this study did not seem to understand the implications of registration, such as the requirement to undertake CPD. Further study could explore whether these views are still valid today. Despite some concern that increased training and responsibility would not be reflected by adequately increased remuneration, it seemed that the advantages of regulation outweighed its disadvantages. These findings are mirrored in a small qualitative study with nine hospital PTs.[18]

The pharmacist questionnaire showed that many community pharmacies were experiencing problems recruiting all levels of support staff, but particularly DAs and PTs. One reason for this, supported by findings from both surveys as well as the focus groups, was the relatively low level of remuneration of support staff. This, coupled with a requirement since 2005, that all categories of pharmacy support staff need to either hold, or be undertaking training towards obtaining, a specified National Vocational Qualification (NVQ) level 2 or 3, may add to these recruitment difficulties. The requirements for formal training and, eventually, regulation (with an expectation to undertake regular CPD) may need to be coupled with adequate remuneration. This would ensure that current high levels of job satisfaction and commitment of support staff are maintained and recognised not just on paper but also in the form of adequate salaries. Support for younger staff who, in this study, were more open to undertaking further training, may need to be different from that for more mature staff who were less interested in further training and career progression.

Conclusion

This study adds important information about the make-up of, background to, and views of, pharmacy support staff to the otherwise relatively scarce literature. Support staff in this

study were generally content with their roles and responsibilities, and younger staff in particular were keen on further training and development. However, with the introduction of minimum competency requirements and regulation, it needs to be ensured that the positive work ethos of support staff is maintained and that additional requirements are adequately rewarded. If successful, this will ensure that the potential benefits of skill mix are achieved for community pharmacy, pharmacy staff and customers.

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