Becoming a professional: Perspectives of community Pharmacy Technicians in England

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Intellectual property and publication statements

The candidate confirms that the work submitted is his own work and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

This study explores community Pharmacy Technician's (PTs) views about being awarded professional status in 2011, with a focus on how professionalism is demonstrated in working practice and its impact on their engagement with learning and continuing professional development.

Research into professionalism rarely considers PTs and Pharmacy Technician (PT) research generally adopts a quantitative approach. This qualitative study engages a hard to reach group through focus groups and interviews. Four locations across England were purposefully selected to give a range of standpoints. Nineteen individuals participated in focus groups with two from each location participating in follow-up interviews. Data was thematically analysed.

Becoming a PT was more often serendipity than vocation, but participants recognised the social value of their role and articulated attributes of professionalism they demonstrated in practice. They set and maintained high standards for patient care, seen as their core responsibility; and engaged in learning, seen as essential for their role and expected by customers.

The initial training and education which this cohort had undertaken did not meet the changing needs of their role, which continued to develop, for example as managers and leaders. There was no formal or consistent access to learning which would enable them to undertake these roles. There was also variation in the support and education provided by other members of their teams, employers and their professional colleague, the pharmacist.

PTs form an active, engaged and competent professional workforce which would benefit from the development of a consistent post-qualification learning programme. Participants made a distinction between ongoing learning needed to do their jobs and the learning needed to assure the regulator they met the fitness for practice standards. New initial education and training standards will start to meet this need.

(285 words)

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Glossary

Accuracy checking	A check undertaken to make sure that the dispensed medicine matches the prescription, is labelled correctly and includes any additional equipment such as medicine spoon, syringe, information leaflet
Administration	The process of giving a medicine to someone whether orally, applying a cream, instilling eyedrops etc
APTUK	Association for Pharmacy Technicians in the UK; the leadership body for PTs
Clinical check	A check undertaken to make sure that a medicine is appropriate for an individual, is a safe, effective and evidence-based option to achieve the therapeutic effect and is aligned with any other therapy that person may be receiving
CPD	Continuing Professional Development is the lifelong process of learning to ensure fitness for practice
CPPE	Centre for Pharmacy Postgraduate Education: a national provider of learning materials for the NHS pharmacy workforce
Dispensing	The process of preparing a medicine for an individual in line with a prescription
Extemporaneous dispensing	The process of preparing a medicine from scratch, typically to meet a particular strength or formulation requirement of a patient.
GPhC	General Pharmaceutical Council: the regulatory body for pharmacy professions
HEE	Health Education England: an NHS body for education and workforce development across England
Medication review	Reviewing the medication that a person is taking for the purposes of refinement, assurance of need and patient safety
Medicines optimisation	Working with a patient to make sure that they are engaged in the process of taking their medicines and that they are on the most appropriate medicines for their condition.
Medicines reconciliation	Checking that the personal record of a patient is a correct description of the medicines that a patient is taking
Pharmacist	An individual holding a degree in Pharmaceutical Chemistry who holds current registration with the General Pharmaceutical Council.
Pharmacy Assistant	An individual working in a pharmacy who holds or is studying for an NVQ level 2 in pharmacy services
Pharmacy Technician (PT)	An individual holding an appropriate qualification in Pharmaceutical services who holds current registration with the General Pharmaceutical Council
Prescribing advice	Sharing expert knowledge on medicines with prescribers to influence improvement in their decision making about medicine choice and use.
Responsible pharmacist	The pharmacist who is legally responsible for services provided from a registered pharmacy premises at any moment in time.

RPS	Royal Pharmaceutical Society: the leadership body for pharmacists
RPSGB	Royal Pharmaceutical Society of Great Britain. This body (no longer in existence) combined leadership and regulatory powers. It was replaced by the RPS and GPhC in 2011.
Superintendent pharmacist	The pharmacist who is legally responsible for the keeping, dispensing and supply of medicines for a pharmacy business.
Supply	Providing medicines to a patient or another member of the health care team

Chapter 1 Introduction – Pharmacy Technicians, professionalism and education

Any individual who offers community pharmacy services in England must undertake, or have undertaken, specific programmes of study. For the pharmacist, this is a four-year degree, supported by a one-year pre-registration period. For the medicines counter assistant, this is an NVQ level 2. For the Pharmacy Technician (PT) this is an NVQ level 3 or equivalent qualification.

Since 2011, PTs have been required to register with the General Pharmaceutical Council (GPhC). They need to have completed an approved programme of study, be able to declare their competence and fitness to practise, and commit each year to undertaking learning, reflection and peer review linked to their professional practice to form their annual revalidation. PTs are designated as professionals by their leadership body, the Association of Pharmacy Technicians (APTUK), and by their regulator, the GPhC. They are a part of the professional pharmacy team.

As a provider of learning resources for PTs, the Centre for Pharmacy Postgraduate Education (CPPE), my employer, is mandated to develop and deliver learning materials that meet the learning needs of the NHS registered pharmacy workforce. This includes learning programmes for both pharmacists and PTs. It is essential that the learning opportunities offered are relevant to the role and professional status of the PT. To do this, it is important to know what this group of learners needs. To provide relevant and appropriate learning, we need to know how PTs understand professionalism and how they are incorporating this into their practice. With this knowledge and in relation to other stakeholder guidance, we can then develop appropriate learning to enable and support their ongoing practice.

Before PT registration became mandatory, Middleton (2006; 2007) explored the views of PTs on what it would mean to become a professional. There is general agreement that professionalism as a concept changes with time, culture and the political environment (Schafheutle, E. et al., 2013; Bernabeo et al., 2014). It seems likely that the views of PTs will have changed since 2006 because PTs now have experience of practising as registered professionals. These changing

views are likely to impact on both the PTs' understanding of professionalism and their engagement with continuing development resources. This research explores whether and how understanding of professionalism has changed and the implications of these changes for educational support to PTs.

1.1 What is professionalism?

There are different groups of health care professionals including nurses, chiropodists, physiotherapists, occupational therapists and paramedics as well as the pharmacy workforce. Understanding what professionalism means for the different groups of professionals concerned has been at the heart of research in this area. The Health and Care Professions Council funded exploration of how professionalism is framed as a concept. Morrow et al (2011) explored what three new professions (chiropodists, occupational therapists and paramedics) understood to be professionalism and found that professionalism related to the individual, the context and the judgements that were made. The report states that professionalism relates to what the individual does with their knowledge in a situation, rather than what the individual knows. Morgan (2014), undertook a Delphi study to explore what professionalism meant to the nursing profession. The Delphi approach offered consensus on the behaviours which were considered to be acceptable and unacceptable of a profession. Morgan's paper extends the work of Morrow to propose a definition of what professionalism is and states that it includes personal qualities of caring, therapeutic relationships with patients and is underpinned by continual learning and development. Morgan concurs that what the individual does is key, but a specialist knowledge is essential as well.

The contextualisation of professionalism for pharmacists underpins work within the UK higher education setting, Schafheutle and colleagues (2012b; 2013) commenced their research by testing perspectives against their definition of professionalism which considered attitudes and behaviours, focused on the Royal College of Physicians professionalism framework (RCP, 2005a). Schafheutle's research has an explicit intention to show that professionalism for pharmacists is directly comparable to professionalism for doctors.

Each of these studies sought to find a common understanding of the meaning of professionalism for a specific profession, or group of professions. They demonstrated the need for the researcher to be explicit about the underpinning concept of professionalism they are using for a specific professional group. It is therefore important for me to be clear about my definition of professionalism to set the scene for this research.

I think that being, or becoming, a member of a profession requires more than developing a specific body of knowledge, committing to behave in a particular manner or submitting to a regulator's requirements.

Larson (1977; 2013) described professionalism as having normative, cognitive and evaluative components. Individuals need to demonstrate a service orientation with distinctive ethics (normative), knowledge and techniques to undertake the role (cognitive), and comparison with other occupations to underscore autonomy and prestige (evaluative).

These were further delineated by Beardsley et al in his study to describe ten characteristics of a professional (2000). Whilst these fit within Larson's three components, his work sought to provide explicit definitions. I have summarised what I see as the relationship between these in Figure 1.

Figure 1. Beardsley's ten characteristics of a professional (2000) related to Larson's three components (1977)

Normative	Cognitive	Evaluative
Service orientation	Unique knowledge and skills	Pride in the profession
Conventional relationship with clients	Commitment to self-improvement	Accountability for work
Ethically sound decision making	Creativity and innovation	Leadership
Conscience and trustworthiness		

1.2 What links education and professionalism?

All professions require individuals to demonstrate a specific body of knowledge and skills to become a member of that profession. However, there is a difference between the nature of education needed to gain entry to a profession and the ongoing learning needed to maintain that professional status. Ongoing learning, through continuing professional development (CPD), is considered to be one of the underpinning essential criteria for any profession (Morgan et al., 2014).

Any person who accesses health services expects that the people caring for them did not stop learning when they entered the profession, but continues to maintain their knowledge, skills and wider awareness of new techniques, new therapies and changes to the structures underpinning healthcare. This continual learning and development is an expectation of all professionals. My investigation set out to explore what professionalism means for those PTs working in healthcare.

CPPE is the largest provider of ongoing learning opportunities for pharmacists and PTs in England post qualification and it seeks to ensure that its learning enables improvements in NHS patient care. As PTs recognise that professional status brings an obligation to learn, it is important to know whether this changes the way in which they choose to learn, or the learning that they need in order to constantly improve and develop.

PTs who are currently registered and practising in community pharmacy may have been working in their roles for several years prior to mandatory registration. Their concept of professional practice will have been shaped by many factors, but formal learning on professionalism was not included in the NVQ3 learning programme that they undertook to gain their qualification. This is an opportunity to explore the ways in which PTs learn professionalism through their practice and how, through this learning, they build and gain a sense of their own professional identity.

1.3 Why Community Pharmacy Technicians?

Professionalism is often described as a set of values, attitudes and behaviours. Increasingly researchers (Elvey et al., 2013) have explored how personal identity is a key component of recognising status as a professional. PTs have only recently gained professional status, which provides an opportunity to explore how practitioners develop and adapt to professionalism. Nairn (2015) undertook discourse analysis to determine how different members of the pharmacy team perceived the professionalisation of PTs but restricted this to an exploration of those working in hospitals in Scotland. The GPhC commissioned a report into the initial education and training standards (IETs) for PTs in the UK. Boughen and colleagues (Boughen et al., 2017) surveyed 393 PTs as part of the investigation into IETs and only gained responses from 71 working in community pharmacy. The authors comment on this being a difficult group to engage in research.

This affords my study an opportunity to explore the perceptions and experiences of community PTs in the early stages of acquiring professional status as they grapple with what this means for their practice, position in society and pharmacy, and their self-identity.

Since PTs are in the process of becoming professionals, I was interested in what processes they have gone through. I wanted to explore their perspectives of the efforts or approaches their leadership body or regulator took to help them to understand this change. I wanted to listen to their opinions on the routes that PTs took to build an awareness of what it means to be part of a profession, to act in a professional way and to be held to account against a set of professional standards.

My research explores the perceptions and experiences of this group of people as they have learned professionalism in their practice, highlighting what made this easier and what barriers to learning and development they encountered. Through asking questions about their perceptions of professionalism, I uncovered new knowledge about PTs, the routes that they take into this work and how they understand, experience and enact their roles.

1.4 Locations of pharmacy practice

Pharmacy teams have traditionally practised in two main areas. The majority of pharmacists work in community pharmacies. These are the premises on high streets, housing estates and village centres across the country. The second largest sector of practice is hospital pharmacy. More recently pharmacists have started to work within general practices where they optimise medicines, advise prescribers and run clinics to offer direct patient care. In each of these settings, the pharmacist works with PTs. As this research progressed it found that these traditional sectors were becoming blurred.

Hospitals have become larger and host retail facilities within their buildings and community pharmacies have started to open within the hospitals. In some cases these pharmacies have a contract with the hospital to dispense medicines for hospital outpatients. In others the hospital has its own outpatients pharmacy and has a contract with the NHS to dispense community prescriptions.

Primary care services, leading on patient care outside of the hospital setting, have recognised the need for effective pharmaceutical care provision and employed PTs in a range of roles to audit and support the safe use of medicines.

This blurring of the boundaries of practice is explored in Chapter four in more detail as it resulted in a range of PTs engaging in the focus groups to talk about their professionalism and development. The implications for the impact this had on personal identity are discussed on page 75.

1.5 Summary and thesis structure

In this first chapter I have offered an overview of the members of the typical pharmacy team and how changes through regulation have resulted in the professionalisation of the role of the PT. This change triggered my interest in understanding how this process was understood and experienced by the PTs. Initially, my interest was in how PTs viewed the requirement to engage in ongoing learning and development, and how this could best be supported by CPPE. As the research developed, I realised that this question of engagement in CPD was closely linked to questions of identity, specifically how professionalisation impacted upon personal identity.

The typical areas and responsibilities of practice have advanced and developed since 2011 and have resulted in blurring of concepts of the typical sectors of practice and boundaries of the traditional care settings.

Chapter two brings together the different threads highlighted in chapter one focused on what professionalism is and how professionalism is taught. It considers how the theory of professional socialisation offers a route to understand the literature, the gaps within it for PTs and thus sets the scope for this research. It closes by stating the research questions

Chapter three presents consideration of research reflexivity and the philosophical justification for the methodological approach used. It outlines why focus groups followed by interviews offered an appropriate, rigorous and robust way to answer the research questions.

Chapter four details the process of carrying out the research. It explains how participants were found and engaged and ethical considerations related to this. It describes how the focus groups and interviews were carried out, how insight from the focus groups was checked and validated through interviews and the framework approach to analyse the data.

Chapter five shares the perspectives of the PTs who participated. It describes the focus groups and the participants both in groups and interviews. It presents the key findings of the research, supported by excerpts from the transcripts and draws together the work to focus on learning and patient care as key markers of enhanced professionalism for a PT.

Chapter six comprises the discussion of the findings and their place in relation to practice, policy and the literature base. It shares concepts of how PTs have developed professionalism in their practice and what steps can be taken to make this consistent across the workforce. It closes with reflections on the research journey itself and the strengths and limitations of this study.

Chapter seven concludes the thesis. It returns to the research questions and outlines how these have been answered through this programme of work. It explores the implications of new knowledge for the profession and the impact that this work has had so far. Finally the chapter proposes future research which could be undertaken to build on what has been learned and uncovered as this research was undertaken.

Chapter 2 Literature review

This literature review explores a range of literature relating to professionalism within the context of health care and health professions education. This maps how professionalism is understood and interpreted in practice, which provides a frame for how professionalism is understood and experienced by PTs.

The specific questions explored in the literature review are:

- What is professionalism? (2.2)
- How is professionalism taught, learned and assimilated into practice? (2.3)

It considers what the implications are for PTs as they practise within a new and developing profession. I then use the findings of this literature review to formulate research questions for the study which explore the perceptions of PTs working in community pharmacy in England.

2.1 Literature search and identification strategy

I undertook this literature review using guidance from standard texts on undertaking research and on appreciating the place, purpose and process of a literature review (Boyne, 2009; Aveyard, 2014; Papaioannou et al., 2015). Since Papaioannou described literature from the social sciences as being more difficult to locate through standard web retrieval methods, I sought additional guidance from my supervisors and from the faculty librarian at the University of Manchester. Further support and information was found on University library websites from both the University of Leeds (Leeds, 2015) and the University of Manchester (Manchester, 2015). This resulted in a strategy that focused on the use of electronic databases for key words, topic domains and contributing authors, with additional supporting, contextual and background information in printed materials and textbooks.

2.1.1 Electronic databases

I used a range of electronic databases, which are listed in table 1. My exploration of professionalism explores literature dating back over 70 years, identified through electronic searching and subsequent paper copy retrieval where necessary. My search period for PTs covered 1/1/2000 to present so that I could identify contemporary work and understanding which I deemed more likely to be relevant to current concepts of professionalism and pharmacy education.

Table 1 - Electronic databases and the literature search

Database	Dates included	Number of citations found	
		Professionalism	Sub search for Pharm*
Embase	2000 to present	8926	825
Web of Science	2000 to present	11675	334
SearchIt @JRUL	2000 to present	1733	851
SearchIt@Leeds	2000 to present	148,248	764
Reuters through EndNote	2000 to present	140	124
Google Scholar	2000 to present	446,000	7590

The primary search term I used was ‘professionalism’, with searches then performed within results to improve relevance. I undertook a secondary search to explore ‘pharmacy’ and ‘technician’ using the same search strategy. My keyword searches included the use of wildcards together with truncation to ensure that articles were included. For example, ‘pharm*’ was used to include pharmacy, pharmacist, pharmacies, pharmaceutical; the results for this search are included in table 1 above. Where the online database offered the additional option, searches were refined to explore the Education Domain. To ensure currency and coverage the key search terms ‘professionalism’ and ‘pharmacy’ were entered into the auto alert system Zetocs^{TM} to gather automated announcements of new articles.

2.1.2 Additional methods of identifying literature

In addition to electronic database searching, specific journal databases were explored to identify non-indexed publications which were likely to be of particular relevance. This included Royal Pharmaceutical Society (RPS) publications *The Pharmaceutical Journal* and *Clinical Pharmacist*.

Publications and policy documents from the Department of Health, Health Professions Council and General Pharmaceutical Council were also included. This gave access to key areas of grey literature, including discussion documents and White Papers. This was an area of particular relevance for my research as professionalisation has been imposed on PTs: it is not something which most PTs have actively campaigned for. This is an example of the impact of governmentality that I refer to on page 52.

I adopted a snowballing technique to locate missed references cited by other authors; this involved checking the bibliography of papers to find new references of potential interest not identified in my original searches.

Finally, I gathered additional information and suggestions through development of collegiate and professional networks. This included supervisors and fellow students at University of Leeds and colleagues at University of Manchester, exploration of the research network Propel at The University of Stirling and more widely through networks and contacts across the pharmacy profession.

2.1.3 Inclusion and exclusion criteria

The strategy adopted resulted in inclusion criteria of a relatively broad nature. At the early stage I did not consider additional refinement as a broad search brought the advantage of including a wide range of experiences and perspectives. My strategy resulted in certain areas being excluded, for example professionalism relating to the law or clergy was not included. The search was also restricted to the English language only.

The decision whether or not to read the full paper was based on titles and abstracts. For example, I excluded letters and articles which were classified as Professional misconduct and were retrieved in my searches. These were linked to summaries of poor practice and removal from registers and were not relevant to my research.

2.1.4 Appraisal and synthesis of literature

I had initially seen the purpose of the literature review being to explore the concept of professionalism and tried to find a definition and develop a shared foundation for exploring its relevance to the new professional role of the PT. It became clear that there was a vast range of literature relating to professionalism and that exploring the entire literature was outside of the scope of this research. As the search developed, it became clear that a single definition of professionalism was not agreed across the literature. There was ongoing dialogue about what constituted professionalism and who can be considered a professional. Indeed, this lack of agreement was central to the concept itself. The tension between competing definitions, perceptions and interpretations, and the implications of this for clinical and educational practice, shaped this research throughout.

It also became apparent that there was jostling for position within the professions; attempts to claim that some professions were more professional than others and a persistent position that some professions were ‘true’ professions, where others were not. This subdivision of professionalism into conceptual groupings, such as true professionals and new professionals was a persistent and value laden theme, which continued through to research up to 2000 (Ladinsky, 1974; Larson, 1977; Hammer, D.P., 2000). This literature encompassed teaching, medicine and nursing roles. I explored this area as the findings of the positioning and ranking of different professional groups related to the new professional status of the PT and its relationship with the professional role of the pharmacist.

I explored my search results further based on the title, keywords, abstracts and, if I deemed relevant, full article content. I explored the content of the articles to determine the nature of the research. I found research on professionalism from across the research paradigms, which meant that I could not carry out a common review approach. I considered articles according to their broad themes; were they exploring attitudes, concepts, behaviours or standards. I explored the rigour of the articles through consideration of the relevance, quality, strengths and limitations of the content and research methods. For quantitative studies this included sample size, time period explored and use of

appropriate statistical tests. For qualitative studies I considered appropriateness of conclusions drawn, strength of evidence being used, and analytical methods used.

As there was a wide range of approaches in the literature explored, it was essential for me to use a flexible approach. I included some studies as they sought to offer competing explanations or insight into the challenges of understanding professionalism, others highlighted tensions or contradictions in the literature and others sought to offer evidence of engaging professionals with learning and demonstrating professional practice.

I have presented my findings in response to the key questions I was seeking to explore and these form the subheadings for subsequent sections.

- What is professionalism (2.2), and
- How is professionalism taught, learned and assimilated (2.3).

Findings of literature review

2.2 What is professionalism

According to the Oxford English Dictionary (2015), key terms relating to professionalism can be defined as follows:

> "Profession: *A paid occupation, especially one that involves prolonged training and a formal qualification*
>
> Professional: *Relating to or belonging to a profession*
>
> *Worthy of or appropriate to a professional person; competent, skilful, or assured*
>
> Professionalism: *The competence or skill expected of a professional*"

These definitions show how self-referential the definition of the word itself is. Professionalism is a contested word (Pring, 2015). As he explains, a contested word is one which is broadly understood, but where differences will appear if asked to define the term. The word professional can be used not only to describe the individual, but also the way in which the individual works, or to add

a cachet of excellence to an activity or role which is not itself undertaken by a professional. As a word, it seems that people understand it when they hear it but can't easily describe or define it.

The concept of being a member of a profession dates back until at least the 17th century (Lee, 2012). The three traditional professions are stated to be theology, medicine and the law (Hammer, D.P. et al., 2003). Members of these three professions practised in Latin, a language which at that time was understood only by members of those professions. Members of the professions could claim to be competent in a specific body of knowledge which was not known by those outside of the profession. Literally they could publicly profess their expert knowledge. They claimed to profess knowledge of a non-tangible element: the soul for the clergy; health for the physicians; and freedom for the law.

This concept of a profession being defined by its expert knowledge has changed over time. Since the 1950s the concept of professionalism has been explored in the literature from a range of perspectives and there have been changes in the way that professionalism is itself described. In the late 1970s Larson's work (1977) initiated a shift from the expert knowledge concept of a professional, offering an alternative approach which sought to consider the additional dimension of understanding professionalism from a societal perspective. Larson's work moved the explorations of professionalism from the knowledge base of a profession, to incorporate the views of society on what made a professional – essentially recognising that people were only professionals because society considered their role to be a professional one and that they demonstrated the traits expected of a professional.

Understanding the traits that the public associated with professionalism formed the foundation of the development of learning materials to teach professionalism in practice, with consideration of traits an approach common to pharmacy education literature. The American Pharmaceutical Association developed a set of ten traits of the pharmacist (Beardsley et al., 2000), which was developed into a white paper (APhA, 2000) setting out the scope and context for pharmacist professionalism. This work also formed the foundation of

studies in Manchester Pharmacy School (Schafheutle, E. et al., 2012b; Schafheutle, E.I. et al., 2013; Elvey et al., 2015).

In her research Nairn (2015) used the structure of medical professionalism proposed by Stern (2006) to analyse the interviews she held with members of the pharmacy team, including PTs, seeking to construct an understanding of professionalism for this group.

The external perspective on what determines a professional developed further from the perceptions of society to the requirements of governmental forces, with a move towards closer regulation of the professions (Allsop and Saks, 2002). In the current working environment it is agreed that any profession must be regulated and its members must be accountable.

2.2.1 Professionals as a regulated community

One of the central tenets of professional communities was their right to self-regulation. The profession itself set the standards required not only to enter, but also to remain a member of, that profession. This was the accepted practice until the early 1980s (Bierig, 1983) when a series of high profile failures of self-regulation led to public pressure and a more open approach to regulation (Klein, R., 1998).

We have now seen the development of a professional as someone who is a member of a group which is regulated, commonly by the government in the UK (Morrow et al., 2011; Morgan et al., 2014). It can be seen that increased regulation has changed the concept of professionalism; “autonomy has given way to accountability” (Evans, 2008, p.21). Increased regulation sought to link professionalism with a role that carries risk. Professionalism became associated with the individual taking responsibility for managing that risk, with a reduced emphasis on the status that membership of the profession gives to the individual. This resonated with the drive to accountability and risk management that followed the move from self-regulation to external regulators. An individual needed to be aware of the risks that are associated with their work, whether this was to patient care, as seen in the health services, legal redress (policing and the law) or the education of children (teaching).

For the PT, this was exemplified by them taking responsibility for the safe and accurate dispensing of medicines, outside of the direct supervision of the pharmacist, whilst the pharmacist was freed to undertake other roles outside of the physical setting of the pharmacy. The PT took responsibility and so needed to recognise the risks associated with their actions and omissions.

Despite this drive to regulate, the long prestige associated with professional practice continued to make professional status an aspiration. The inherent conflict of whether professionalism was described by accountability rather than autonomy and was driven by an entry standard rather than an enduring aspiration to excel, may have had an impact on the self-belief and drive of the individual. For an occupational group which has been designated as professional through regulation, there was an opportunity to explore whether that became the prime driver for professional status, or if the members of this profession created an intrinsic value linked to a new status: essentially to consider the dynamic processes that link regulation status and prestige. This was key for considering the development of a new profession. There may be a concurrent development of what Sachs (2001) describes as democratic professionalism (that claimed by the professionals themselves) and managerial professionalism (that described by authority).

As the new PT profession is formed, the question of where it finds its position is of particular relevance for the PT. Democratic professionalism is the aim of the PT leadership body which seeks to claim a professional position as an aspiration and mark of excellence and status. Managerial professionalism is defined by the regulator which describes what is required of the PT, constructs the entry standards requirements and determines the ongoing requirements for membership.

2.2.2 Professionalism and hierarchies

The links between status and being a member of an elite group are evidenced by arguments that continue in the literature over whether any group other than the medical and legal professions can be said to be professionals. These arguments considered issues of authenticity and entitlement. Authors sought to find ways of describing alternate groups of professionals. These include what Agomo (2012) described as the ‘new’ professions of engineering, chemistry and

the natural sciences; ‘semi’ professions such as nursing and pharmacy and ‘would be’ professions such as business managers. There is an underlying conflict in the discussions I found within the literature about whether some professions were more worthy than others.

This can be explained by an apparent drive from ‘true’ professionals to retain the scarcity value of the concept by preventing the growth and development of other groups to acquire the same status. I believe that this is, to some extent, related to the concept of différance, a theory introduced by Derrida (1981). He described the concept of a violent hierarchy in which the presence of one grouping prevented the development of another. Although Derrida was focusing on the use of language, this description of some professions as being more worthy is fundamental to how language is used to describe different professions; NHS white papers continue to refer to doctors and other clinicians, reinforcing the status of doctors as different to any other clinician. It has been claimed that the presence of the ‘true’ profession of the doctor prevents the development of nurses and pharmacists as true professions (Donnison, 1977). If this argument is extended to the pharmacy profession, where the two professions of the pharmacist and the PT work even more closely together, it is possible that the presence of the profession of the pharmacist prevents the development of the profession of the PT. The overlap between the training required for the two roles, their place in practice and the interdependency of the two roles seemed likely to result in potential conflict over professional positioning.

From this review of the literature it can be seen that there was no common agreement on what professionalism was and that this debate remained central to the concept. The current concept of professionalism was different to the original with a shift from the expertise of the professionals through to an acceptance and recognition from the wider society. Where initially professionalism was defined and recognised by its exclusivity and power, currently there was a stronger sense of accountability with power being exercised over, as well as by, the professional. The inclusion of regulatory power over professionals has become one of the required markers of a profession.

2.3 How is professionalism taught, learned and assimilated

Over recent years the focus in the literature of professionalism within the healthcare professions has been on how people are taught professionalism during an initial programme of study. Work has been published that seeks to explore how professionalism can be included in the undergraduate curriculum. Schafheutle has led much of this work in the UK for undergraduate pharmacists and found that students linked professionalism with the way that pharmacists worked in practice (Schafheutle, E. et al., 2012a) and that they related their concepts to what they saw as role model practice. A key feature of her work was recognition of the alignment in perceptions of pharmacist professionalism and that of students in the US in work undertaken by Hammer et al (2000). Rutter (Rutter and Khalid, 2010) also explored pharmacy students' understanding of professionalism. Although Rutter's work also found alignment with the work of Hammer (2003) and Beardsley (2000), his findings suggested that the understanding of professionalism for undergraduates remained relatively superficial and related to concepts of appropriate clothing and language rather than knowledge, expertise and trustworthiness. Schafheutle (2013) extended her work to consider the implications of improving deeper understanding of professional practice for the higher education institution and stressed that there needed to be alignment between the intended, taught and received curriculum.

Although aligned with other health professionals and the international knowledge base, research in the UK has focussed on how undergraduate pharmacist students are taught to become professionals and the different elements that need to be in place to enable this. There was no similar body of research exploring these factors for PTs. Commissioned by the GPhC, Schafheutle undertook an investigation into the initial education and training of PTs which found that there was no content on developing professionalism or understanding professionalism, which means that PTs are not gaining learning or understanding of it through their taught studies. The teaching of professionalism is being introduced with a new set of initial education and training standards for PTs which commenced in the Autumn of 2020.

I am interested in whether practitioners recognise that professionalism is not just about earning the status, but also about maintaining it through ongoing learning and development. Beardsley (2000) described this as a commitment to self-improvement. This had special relevance for this relatively new professional group of PTs, for whom there has been little formal learning provision on becoming a professional.

At a post-qualification level there was less published work. Outside of undergraduate investigations, Jee (2016) and more recently Ireland (2019) have explored how postgraduate pharmacists are taught to become professionals in practice in their pre-registration year. These studies both made use of the theory of professional socialisation, an approach described by Weidman et al. (2001) which considered the many facets of professionalism and how they are assimilated into practice.

My research involved exploring what needed to be included to encourage learning amongst the post-registration PTs who are unfamiliar with formal Continuing Professional Development (CPD) requirements. Within the literature of professionalism and educating for professionalism, the concept of professional socialisation offered a way to understand the different stages at which professionalism was learned in practice. This focus on why people choose to enter a profession, how they learn to become professionals and what approaches they take in order to maintain that professionalism was highly relevant to my research and I have therefore used the concept of professional socialisation to structure the findings of my literature review in respect to how professionalism is taught, learned and assimilated.

2.4 Professional socialisation

In his report, Weidman et al. (2001) reviewed ten years of research and thinking related to how professionalism was learned and assimilated. Weidman's focus was specifically on those roles considered to be professional because of the complex expert knowledge that was needed and the length of time taken to enter into that profession. These two factors of learning and time formed the essential structure for a series of interactive processes that supported the

development of an individual into a professional. Weidman described three stages each of which related to and interacted with the others.

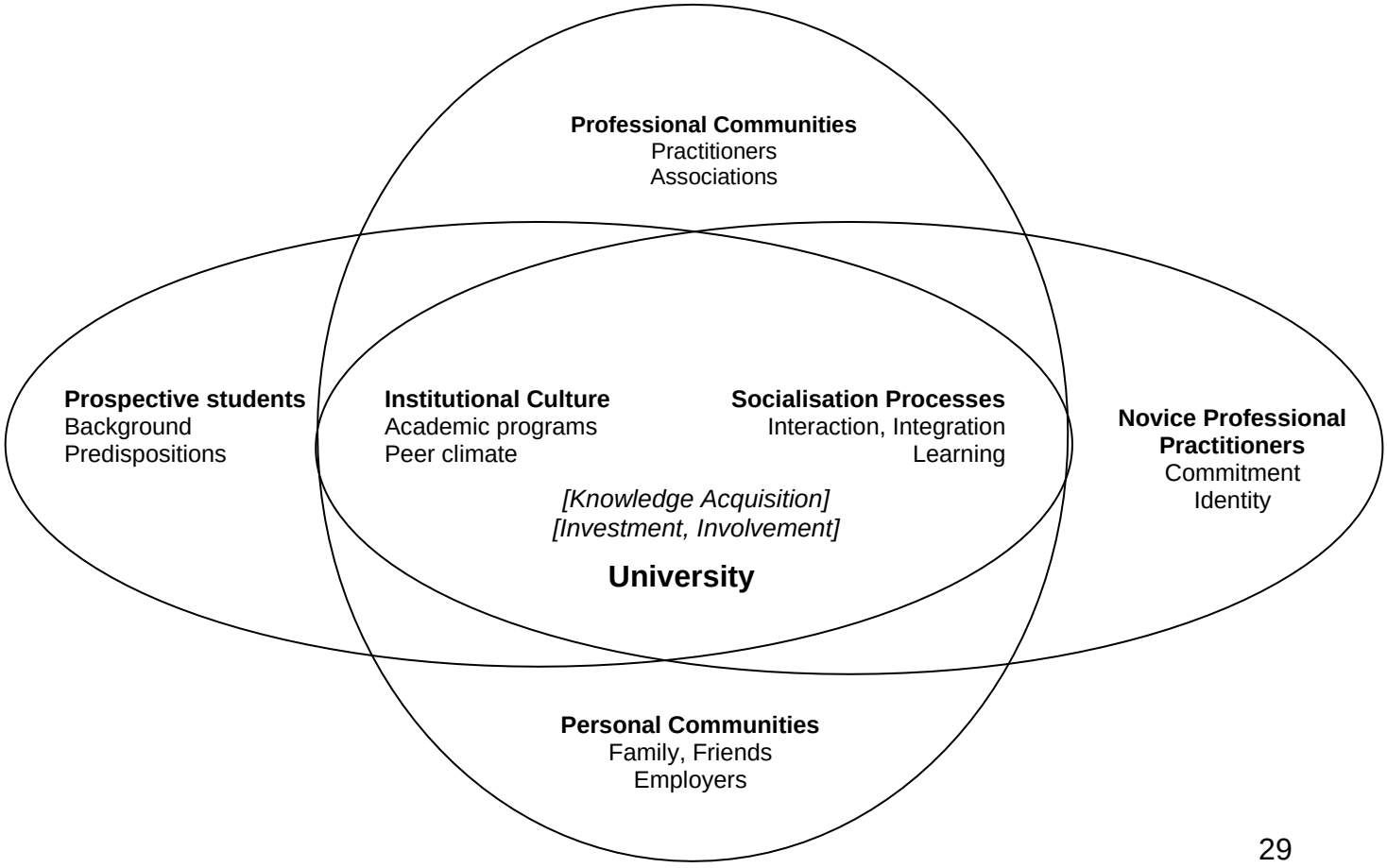
Anticipatory socialisation – identifying oneself as being suitable for a particular profession and preparing to enter it.

Formal training – engaging in the required learning programmes to gain the knowledge needed for that profession, learning the skills and demonstrating competence to enter it.

Post qualification – recognising the need to continue to learn and develop in order to remain a part of the profession's social group.

These three stages interact with each other, as outlined in figure 2. For example, role models seen as tutors during the formal training will engage the interactive stages of socialisation: anticipatory, formal, informal, anticipatory socialisation of the student; students will identify themselves with that role model and seek to emulate them. Students may also carry this identity into their practice post qualification.

Figure 2. Stages of socialisation (Weidman et al. 2001)



2.5 Anticipatory Socialisation

The first stage of professional socialisation (Weidman et al., 2001) occurs as the individual recognises that they want to become a member of that profession and visualises themself fitting within the social norms and perceptions associated with that profession. This was recognised in early work by Middleton (2006) who used the model of professional socialisation to underpin her exploration of PTs joining a voluntary professional register. However, her work does not consider other aspects related to anticipatory socialisation.

For the majority of PTs in 2017 (when the data gathering for this study took place) their role had not been part of a profession when they entered it; it became a profession in 2011. Understanding the concept of being a professional as a PT was therefore of importance and so was explored in the study.

2.6 Formal training – being taught to be a professional

The second stage of professional socialisation is to gain the knowledge and skills needed in order to gain entry to that profession. This aspect has been explored widely in the literature with particular bodies of work linked to health and social care. This work explored approaches that can be taken to teach not just the knowledge and skills but also the behaviours, attitudes and values that form professionalism itself, which are considered to be needed to enter a profession.

Over the last 20 years there has been a focus on how education providers teach students to become professional with much of this work being done in the field of medicine. The Royal College of Physicians sought to describe the traditional role of doctors as professionals using a competence framework (RCP, 2005b). This framework attempted to support its members in understanding the current culture of multidisciplinary professional practice, so that it could be demonstrated and taught to future generations of medics. The literature related to teaching professionalism in medicine was wide ranging. Cruess and Cruess (2006) focused on the expert knowledge required to enter

the profession and the cognitive aspects of professional practice. Arnold (2002) and later Wilkinson (2009) sought to determine appropriate and fair methods to assess whether undergraduate students had attained professional characteristics. Taking into account the impact of institutions and role models on learners, Carrese (2015) investigated the impact of, and variation across institutions teaching professionalism. And from a more philosophical stance Glenn (2012) explored whether it was possible to be a professional when an individual was salaried to undertake an occupation, with Brody and Doukas (2014) looking at the wider philosophical nature of professional practice. Other groups developing professional status such as the police force (Carter and Wilson, 2006), physiotherapists (Candy and Hopkins, 2015) and nursing (Morgan et al., 2014; Rees et al., 2015) have also explored the concept of teaching professionalism.

There has been a focus in the status of teaching as a profession over this time period with a particular emphasis on the impact of increasing regulation making it of relevance to this study on PTs. Sachs (2001) explored the impact of regulation on professional identity, with Day (2002) considering the impact of an enforced curriculum on the autonomous practice of a teacher and Popa exploring how autonomy could be regained (Popa and Acedo, 2006). Evans (2008), Demirkasımoğlu (2010) Gerrard and Farrell (2014) and Kilinc (2014) proposed new definitions for and approaches to teaching professionalism following these regulatory changes. Research within pharmacy has focused on teaching professionalism to pharmacists (Schafheutle, E. et al., 2012b; Schafheutle, E.I. et al., 2013), rather than PTs.

In the US, there has been a strong focus on values-based teaching of professionalism as well as the content and curriculum. Authors described the informal learning that was instilled through the values of the institution, with a call to ensure that these were aligned with the desired culture (Berger et al., 2004; Doshi, 2003). For health professionals there was recognition of the need to be multidisciplinary (Brehm et al., 2006) to meet the needs of a modern health work force.

Specifically in pharmacy in the US, work to define the concept of professionalism, its teaching and assessment was a focus between 2000 and

2006 (Beardsley et al., 2000; Hammer, D.P. et al., 2000; Hammer, D.P., 2000; Hammer, D.P. et al., 2003; Hammer, D., 2006; Chisholm et al., 2006). This work formed the backbone of the later work of Schafheutle in the UK. Later work sought to gain understanding of students' perceptions on how they were taught professionalism. In the UK, the focus has been on understanding how professionalism was taught, the impact of the organisation on this and perceptions of recent graduates (Schafheutle, E. et al., 2012b; Schafheutle, E.I. et al., 2013; Elvey et al., 2015).

Daresh and Playko (1995) considered that at the end of the formal training period, the student of an area of professional practice should be able to respond to three questions:

- What do I do with the skills I have learned?
- What am I supposed to look like, and act like, in my professional field?
- What do I as a professional look like to other professionals as I perform my new roles?

Being able to respond to these questions enabled the individual to provide an explicit description of how they knew that they have gained the required level to demonstrate professionalism in their practice. This was predicated on an assumption that the role that they have qualified to undertake was one which would be judged to be that of a profession.

In recognition that there continued to be a discussion over whether being a pharmacist was a profession, Schafheutle and colleagues (2012b) took the focus within their research into pharmacist undergraduate programmes to demonstrate that the occupation for which the student is being trained was one which was worthy of being called a profession. Schafheutle's work sought to demonstrate not only that there was a discrete body of knowledge which must be gained, but that the student must engage in specific behaviours, dedicated to the needs of a patient or a fellow professional.

2.7 Post qualification - becoming a professional

Undertaking a qualification and passing a final assessment of some sort is the common entry point for an individual to enter a profession. This is the point at which the individual can join the register and so claim status as a professional within a regulated profession. The role that they undertake is defined, entry standards have been set and the individual meets those criteria. This third and final stage of professional socialisation considers the ways in which a newly qualified practitioner learns how to become a professional in practice. For my study the particular relevance here related to the enduring need to engage in continuing professional development; a key aspect of professional practice is a need to stay up to date within an expert field that is constantly changing and developing.

The post qualification stage of professional socialisation looks at the assimilation of behaviours and ways of working. For the pharmacy profession these are described by the regulator and embodied in the profession's code of conduct.

2.7.1 Regulatory requirements and codes of conduct

Currently, becoming a professional requires the individual to gain an appropriate qualification and, in the case of health professions, to register with a regulator. This permits the individual to describe themselves as a member of that professional group, which is an employment requirement. Each profession has its own code of conduct, or code of ethics, that describes what an individual must demonstrate in order to be a member of that professional group. Members are expected to act in accordance with that code and are disciplined if they don't.

The regulator and leadership body agreed seven principles of professional practice, a code of ethics, for the PT (GPhC, 2014). These formed the pharmacy code of ethics, which was common to and shared by both pharmacists and PTs. They were updated to a set of nine principles in 2019 (GPhC, 2019) and are described in figure 3.

Figure 3. GPhC Professional Standards (GPhC 2019)

In common with other health care professions, pharmacy practitioners were required to demonstrate certain behaviours of good performance, and values of putting others first. There was a clear commitment to developing the knowledge and ability of the practitioner on an ongoing basis. This was central to the final stage of professional socialisation; one did not simply become a professional through gaining a qualification but must engage in continuing learning and professional development to retain that professional status. The professional knowledge and skill set of the PT will differ to that of the pharmacist but the code of conduct remains common.

Applying theoretical learning in practice requires working with other people. Professional development may come through learning from others and their practice as well as through formal courses. Socialisation of learning considers

the impact of colleagues and communities on the ongoing development and practice of the individual. It is worth considering what professional communities a PT may be a member of, and what the impact of these on their professional identity may be.

2.7.2 Continuing professional development as a marker of professional practice

Weidman (2001) based his model of professional socialisation on an understanding that a professional was one who had to develop expert knowledge in a particular area and that this knowledge took a long time to gain. For health care, as with other areas, the nature of the knowledge that was needed changed with time, research and new understanding. The medicines which were available and in common use at the time of qualification will differ throughout the working life of pharmacy practitioners. Taking account of this, the GPhC included a requirement to engage with continuing professional development within the code of conduct for the professions. There was also an annual requirement for pharmacists and PTs to undertake revalidation. The process of revalidation required the individual registrant to record and submit four pieces of continuing education, a reflection on practice linked to professional standards and to engage in a peer review with an appropriate colleague. Engagement with CPD was a new element for PTs when they were required to register in 2011. Within the UK, Schafheutle (2013) undertook a review of approaches to revalidation and concluded that different requirements could be appropriate for pharmacists and PTs. The GPhC continued to set the same requirements for both registered professions.

The international literature has described approaches to engagement of PTs with ongoing learning and development in order to undertake new roles outlined in the US (Lifshin and Nimmo, 2001; Sewchok, 2002), and in Canada Krevesky et al. (2012) described the development of a formal CPD programme specifically for PTs. The focus of these articles was on the content, structure and acceptability of the programmes rather than whether they impacted on the status or identity of the PTs who undertook it.

Professional socialisation offers a way of understanding how professionalism is taught through the content of learning programmes, culture and approaches of institutions and attitudes and behaviours of role models. It proposes additional elements of learning for professionals who start to model their identity and perception of themselves on their knowledge and awareness of a professional group before they start to join it. And it explores how the process of being a member of the profession continues to develop and grow after gaining entry to it. As PTs seek to create a new profession, these different elements of socialisation offer areas to explore with PTs to build a richer understanding of their perceptions.

2.8 The Pharmacy Technician and a move from occupational to professional identity

Having considered the theory of professional socialisation, it is now appropriate to explore what this means for PTs. It has long been standard practice in community pharmacy in England that the pharmacist is supported by other members of staff. Those who showed an aptitude and ability would be asked to work in the dispensary, aiding in the complex and essential task of filling prescriptions. This role was variously described as a dispenser or technician. It was possible, though not required, to undertake a specific qualification most recently known as the BTech in Pharmaceutical Services.

PTs were required to register with the General Pharmaceutical Council in 2011. From this point they were considered to be health care professionals by the regulator and the APTUK, their professional leadership body. Pharmacy Technician became a protected term; only those who have completed an appropriate qualification and are registered may use this title. However, the role of the PT in community pharmacy does not appear to have changed its nature as a consequence of regulatory changes.

This was not the case in hospital pharmacy practice where the role of the PT has developed to encompass direct engagement in patient care, medication history taking and wider roles within a team over a 20 year period practice (Michels, 2003 ; Turner et al., 2005; Wick, 2008; Bright et al., 2009; van den Bemt et al., 2009; Remtulla et al., 2009; Pierard et al., 2011; Puech et al.,

2011). This development was greater in the UK than in other countries (Alkhateeb et al., 2011) potentially leading to a widening gap in the practice of PTs in these different healthcare settings.

Since the PT role only became a profession in 2011, the majority of those in current practice selected the role as an occupation not as a profession. Anticipatory socialisation is the stage where an individual sees themself as a future member of a community of like-minded professionals. Evidence was not available in the literature on why PTs select this role, or whether it was perceived as a professional role by them. My research sought to begin an exploration of this area and to gather the perceptions of PTs on their professional status and their engagement with professionalism.

2.8.1 Justification of professional status

PTs are likely to continue to struggle to be recognised as professionals (Schafheutle, E.I. et al., 2012). Of the 13 professions regulated by the Health Professions Council, none have anything less than a degree level entry point; indeed, nursing was not considered a profession until it offered degree level entry. Entry for PTs remains at NVQ level 3, a qualification which is lower than a degree. The formal learning programme focuses on the occupational standards and technical competences required to gain the qualification.

As the content of the qualification was taken from parts of the pharmacy degree – with a focus on extemporaneous dispensing and technical aspects - it was also difficult for PTs to argue that they had a discrete body of knowledge which was not owned by anyone else. The pharmacist was taught a wider curriculum and in greater depth than the PT. However, my research did not seek to establish the accuracy or wisdom of the decision to require PTs to register as professionals. Rather, given that this requirement was enacted in 2011 my purpose was to explore how PTs understood and conceptualised their professionalism and how they maintained their competence within practice.

PTs work in both hospital and community pharmacy, with a common qualification required for both practice settings. The roles differ widely, with a community PT often being seen as a more competent dispenser, whereas a hospital PT may engage in patient advice, medicines reconciliation and review.

An investigation into the programmes of study offered to PTs was undertaken by Schafheutle and colleagues in Manchester Pharmacy School (Schafheutle, E et al., 2017). This found that “professionalism (attitudes and behaviours)” was lacking within the taught curriculum for PTs across the UK. It also found a difference in programme evaluation from hospital PTs (who considered the programme to be lacking in clinical content) and community PTs (who considered the programme to be too challenging). As a result of Schafheutle’s work, the GPhC has agreed a new set of standards for the initial education and training of PTs and from Autumn 2020 the required qualification to enter the profession will include teaching of professionalism.

At the time of my study, professionalism was not taught as part of the formal learning programme and so my research contributed to understanding how PTs gain learning related to professional behaviours and attitudes.

2.8.2 Socialisation of learning and Communities of Practice

As PTs begin their professional practice, they become members of two distinct communities. The first of these is the wider community of the PT profession, the second is the community of colleagues in their daily working environment. Wenger (1998) described the learning that an individual gains through participation in their environment as the community of practice.

PTs are commonly engaged in practice in secondary care (hospital) or community pharmacy practices. These work settings are different, with different responsibilities for the PT and different communities of practice. The hospital PT will work as a member of a large pharmacy team, consisting of pharmacists, PTs, pharmacy assistants and administrative and clerical staff. The community PT will work as a member of a small team, typically consisting of a single pharmacist, single PT and one or two medicine counter assistants.

The impact of the community of practice will therefore be different for these two groups. In the community pharmacy setting, each PT was likely to be working in a single, localised and bounded field of practice (Fenwick et al., 2012). The hospital PT will have access to a wider team and environment, working in the dispensary, ward and clinic settings with a range of professional colleagues. The impact of the immediate team seems likely therefore to have a particular impact on the development of the community PT as a professional practitioner.

The role of the community pharmacist in England has developed over recent years. The 2005 Community Pharmacy NHS Contract started a movement from payment for dispensing to payment for services. Community pharmacists now typically offer a range of professional services. These include smoking cessation support, provision of emergency contraception to substance misuse support, needle exchange and other public health services. As the national community pharmacy contract shifted the focus to the provision of services, PTs were taking more responsibility for safe and accurate dispensing of medicines.

The law requires that the pharmacist be on the premises whenever the pharmacy is open. As off-site services are developed, the PT can take a role in offering these services on behalf of the pharmacy. This typically included services provided to residential and care homes with their community of practice broadening to include a wider range of health care colleagues.

These changes in community pharmacy practice saw the PT in the community pharmacy take increased responsibility for their standard occupational role of dispensing, greater autonomy in offering services from the pharmacy without the direct supervision of a pharmacist and a greater presence as a member of the wider healthcare team. Each of these changes opened up new areas of potential professional identity and areas of exploration for my study.

2.8.3 New roles for Pharmacy Technicians

Although PTs were taking on new roles within the community pharmacy setting, for example as store manager and in the provision of services to residential and care homes, the research into this area of practice was limited or unpublished at the time of writing. There was limited research into the role of the PT outside of the community pharmacy practice.

PTs were able to develop their practice in a range of roles. Keresztes (2006) described a number of roles performed by PTs in the US. With the exception of those linked specifically to the systems and processes of a health insurance-based system and its associated financial requirements, these roles were applicable to UK practice. These are listed in Table 2.

Table 2 – Pharmacy Technician work environments (Keresztes, 2006)

Medication–inventory control specialist	Long-term care technician
Intravenous admixture specialist	Home care technician
Third-party billing specialist	Durable medical equipment supplier
Pharmacy benefits manager	Narcotic control technician
Clinical PT	Medicare Part D specialist
Nuclear PT	Managed care technician
Education and training coordinator	Quality assurance/staff development
Pharmacy software specialist	Automation technician
Investigational drug technician	Mail-order technician
Supervisor with tech-check-tech	Pharmacy department manager
Medication assistance programs (PTs for Operating room patients not fluent in English)	Compounding technician responsibilities
Speciality areas: wellness, scheduling, limited policy/procedure, antihyperlipidemia, antithrombosis responsibilities, problem resolutions, clinics, immunizations, patient care triage	

Although other international research identified positive roles for the PT in the community pharmacy setting in the Netherlands and Sweden (Pronk et al., 2004; Olsson et al., 2014), these focused on using a PT to enable the pharmacist to offer more services rather than focusing on the development of the PT or of the role of the PT.

There was limited evidence to show that where the PT was able to identify and lead in new areas of practice they were able to build their perceived professionalism. A paper investigating the impact of robotics on roles within hospital pharmacy found that PTs felt that the robot professionalised their role (Barrett et al., 2012) as programming and maintaining the robot became their unique speciality.

The predominant focus in the literature was of using a PT differently to enable the development of the pharmacist. This was evidence of the conflict that PTs experience as they seek to claim their professional expertise and confirm the scope and boundaries of their practice.

Recognising the particular expertise of the PT in technical and dispensing skills, pharmacy students in the US have been taught these topics by PTs (Mack, 2008; Hudgens and Park, 2011). The research explored the ability of the PT to teach the skills and its acceptability to pharmacy students. Although the research was exploring a development of professional practice, the language of these articles reinforces the hierarchy within the pharmacy team. The article made it clear that the PT was teaching the pharmacy student how to undertake a task for which that student (on qualification) would then supervise the PT who had taught them. This role reversal was made explicit as the study acknowledged that this teaching of a future supervisor may cause resistance in engaging in effective teaching. The findings were that, despite not being taught how to teach, PTs were competent at teaching their skills to pharmacy students and that this was acceptable to the pharmacy students; it did not explore the feelings or perceptions of the PT.

Further evidence of the restrictive impact that pharmacists may have on the growth of the PT role can be inferred from studies which have explored roles outside of pharmacy practice for PTs. When the PT moved into a role outside of the supervision of a pharmacist, research has found positive outcomes for this engagement, for example McGraw and colleagues (2012) found a positive contribution through including a PT in a community nursing team.

Although the published evidence was limited, this literature review has found the PT was capable of undertaking a wide range of roles covering patient care, system and people management, education and new service development. There was evidence that the PT displayed the characteristics of a professional, including an ability to act autonomously, engage in learning and take responsibility for personal actions, but research did not explain how or where these characteristics had been gained.

2.9 Challenges for the Pharmacy Technician

It can be seen that, through the lens of professional socialisation, there are many challenges for the PT as a professional group. As a new profession, anticipatory socialisation will be limited because there has not been a stable role for potential members to identify with or set themselves within.

In the formal educational setting, there remains disagreement over whether the level of learning is detailed enough to be worthy of a professional group, or unique enough to be claimed as owned by the profession. For the vast majority of those in practice, learning was undertaken entirely as a non-professional concept and process. Indeed, evidence has found that the content or scope of the learning programmes has not changed since registration became mandatory in 2011; explorations of taught content (Schafheutle, E et al., 2017) found that professionalism is missing from the curriculum.

For hospital-based PTs there is a high potential for engagement with professional role models. These role models will be seen not only in the pharmacy, but also in the other professions working on the hospital site. These other professions include doctors, nurses, physiotherapists, dieticians, paramedics and business managers; there are many role models for professional behaviours and attitudes. There was no published evidence on whether explicit links are made to learn from these role model opportunities or whether any guidance is offered to gain this learning in practice.

For PTs working in a community pharmacy setting the professional role model will be the responsible pharmacist for that practice. Indeed, their daily practice is under the supervision and control of a single dominant professional and advancement in their role as a PT may require competing with the role of that pharmacist. For those PTs in more developed positions, role models will be seen working in care and nursing homes outside of the pharmacy setting itself.

Professional practice is in part described by a shared knowledge and an established convention for practice. For PTs in community pharmacy, the shared knowledge is defined by the NVQ at entry level. Traditionally the conventions of practice relate to completing the tasks assigned by the pharmacist, but these are conventions of an occupational role not of a

profession. With changing patterns in community pharmacy practice, PTs may perceive a need to take on new responsibilities for knowledge and seek out new opportunities for engagement (Fenwick et al., 2012). It is possible that the presence of another profession seeking to occupy similar territory results in the quashing of these personal aspirations.

Understanding the development and learning needs of the PT requires an awareness of why they choose to engage in learning. It would be relevant to explore their perceptions of the particular challenges that this brings and whether it is something that they see to be imposed on them, or something that they recognise and embrace. If they choose to learn, then the question becomes to what extent are they able to access learning which supports their development and continues to challenge them to improve. Is the learning aimed at professionals, at professional development and at a growing role, or is it aimed simply at maintaining a status quo, lacking in challenge and designed to make it easy to tick a box saying that something has been learnt.

2.10 Conclusion: how the literature review shaped the research

Professionalism is a concept which changes with time and culture. The current movement is for groups of practitioners to be identified as professionals through being subject to regulation. However, the concept remains nebulous and multifaceted.

Professional socialisation offers a route to understand the teaching, learning and assimilation of professionalism. It considers the anticipatory, formal and post qualification aspects of socialisation and the ways in which these interact. There is limited published evidence in these areas related to PT practice. In particular there was no available commentary on the anticipatory socialisation of the PT or of the postqualification development of professional identity.

PTs, as a group, have demonstrated an ability to take on new roles and lead development of teams and services where these opportunities have been explored. PTs are now regulated as professionals and are required as such to engage in a reflective process of continuing professional development. They

have personal responsibility for developing their own knowledge and practice. In community pharmacy practice, PTs work in small teams and the only other professional working in their immediate practice is the pharmacist. Their self-identification as a professional will be impacted by their working environment and the support of the pharmacist who works alongside them and manages them. Exploring the PTs' concepts of professional practice, and the routes that they use to identify and select learning opportunities, will begin to explore the development of their professional identity as novice professional practitioners.

2.11 Research questions

The role of the PT has moved from an occupational to a professional position but there has been no national programme of work to engage the PT workforce with understanding and developing this changing mind set. Without a formal programme of study to provide the underpinning knowledge and practice of professionalism, it is important to explore how PTs gain an understanding of this concept. This leads to the first research question:

> **What do community PTs in England understand by the concept of professionalism in the context of their working lives?**

At the time of this study taking place, PTs had been practising as professionals for a six-year period. This offered an early opportunity to explore whether the understanding of professionalism was impacted on by the length of time that an individual had been working as a PT. Thus, a subsequent research question is:

> **Is that perception affected by their generation of practice in relation to the onset of regulation?**

Ongoing education is the only method by which PTs will have gained knowledge of professionalism and sharing a record of this is an annual requirement from the GPhC. Engaging with CPD is one of the main changes that took place for PTs on registration so is an important area to explore. This brings two new questions to answer:

> **Do PTs perceive a link between CPD and their professional status or practice?**

How do community PTs meet the CPD requirements of their professional status?

Finally, as this work seeks to build a greater awareness of the approaches that PTs take to build and accept their new professional identity and agree the limits of their professional role, it is important to understand the factors that support or limit this practice change and what the implications of this are for their engagement in ongoing learning.

What barriers, and what affordances, do they encounter in meeting these requirements?

What are the implications of these findings for ongoing learning for community PTs?

In the next chapter I will consider appropriate approaches to start to answer these questions.

Chapter 3 Conceptual framework for study, aim and objectives

In this chapter I seek to make sense of my personal philosophical stance and how through the taught components of my EdD studies I gained a greater awareness of the factors that shaped my own world view. I explain how understanding these philosophical influences helped me to gain clarity of what I was trying to explore with my research and how this led to the approaches of focus groups followed by one to one interviews that I took to gather data. As ethical considerations are so closely interwoven with philosophical thinking, I have included a discussion of the specific ethical challenges of this research.

3.1 My personal philosophical stance

There is a link between my professional values as a pharmacist and my developing values as a researcher which was important in my research design and operation. My own professionalism values shape my world view. These are my values as a pharmacist, my role as an educator and my authority as a professional leader. Through these I have my own perception of what it means to be a professional and the subsequent obligation to maintain practice through ongoing professional development.

I also bring values linked to my employment at CPPE: my employer has funded my research and expects to get a useable output. This output may support the development of learning materials, or the development of a learning environment, which more closely meets the needs of PTs. Linked closely to what my employer requires, I recognise my own desire to develop effective and enjoyable learning materials and believe that this is best achieved through determining learning content based on the need of the learners, which I believe links to their professional role and practice. I chose to undertake research based on practice and so my investigation sought to support PTs in understanding the development of their role, accessing appropriate and relevant learning and in making an informed choice about their engagement in this professional group.

According to Pring (2015, p.9), a philosophical examination of the research question must start by trying to gain clarity into the nature of that which is to be

researched. This chapter outlines how I have tried to gain that clarity and the approaches that I took in order to make sure that the knowledge I gained could be verified.

Understanding the theoretical framework underpinning my research was a central part of the learning that I gained through undertaking research and this chapter articulates some of the challenges and moments of insight that I gained during my studies and research.

3.2 Axiological considerations

It is important that my discussions consider what I bring to it as a researcher. These axiological considerations not only influenced my choice of research investigation, but also the approach that I take to research and my interpretation of the findings. I decided to undertake practice-based research and so the link between my professional values as a pharmacist and my developing values as a researcher were important in my research design and operation.

My desire to undertake research based on practice resulted in an investigation that sought to support PTs in understanding the development of their role, accessing appropriate and relevant learning and in making an informed choice about their engagement in this professional group. This awareness of what I brought, what my employer wanted and what I sought to deliver as an outcome of my research formed the axiological underpinning of my study. Recognising this allows me to make these links explicit in my research.

Through my research I tried to find a balance between allowing myself to engage in the research process and securing approaches that minimised the impact that my own opinions and world views have on the work that I undertook. I recognise that research is not just about redefining and exploring personal value positions, but also has ontological and epistemological considerations. These are addressed in the next sections.

A further area that I became aware of during my studies, initially through guidance from my supervisors and then on further reflection through my own experiences and practice, was the impact that I had on my research and conversations through my own identity and professional status as a pharmacist.

This came as a big surprise to me initially. I saw no barrier to PTs being considered professional and treated with respect, and so did not expect assumptions or barriers on the part of the PTs.

I started my career in industrial pharmacy, where there was little distinction between pharmacists and PTs – the person with the right skill set to do a job was the person who was employed to do it. When I moved to hospital pharmacy practice, it was to an environment where PTs were working as managers of the dispensary and where their knowledge of the working environment was greater than mine. So again, I learned from them and enjoyed working alongside them. When I took on a role in community pharmacy practice, I worked to engage my team of PTs in the same mindset. Whether it was through my role as a tutor and mentor during their studies, or through allocation of roles and responsibilities within the dispensary, I saw them as equals but with a different role.

I left community pharmacy practice and worked as a service development co-ordinator for the National Pharmacy Association. In this role I was supporting pharmacy teams as they set up new services to improve care for their communities. I found that the success of a service depended on the engagement of the whole pharmacy team. The PTs were essential partners for a service to work effectively.

When I moved to CPPE, I took on the remit of investigating what support we could offer for the nascent profession of the PT. We started by listening to their needs and working with the vanguard of PTs who sought to explore the potential and boundaries of this new role. These early PT professionals were pioneers and engaged actively in planning for the future and exploring new opportunities. When registration become mandatory in 2011, the proportion of engagement dropped off. This change was one of the early factors for me considering research in this area. I recognised that research in this area was about gathering concepts and so a qualitative methodology was an appropriate way to explore this practice issue.

When I see a PT, I see a skilled individual, highly capable and with a huge potential for personal development and growth. I did not see that this could be a barrier within my research.

My supervisors invited me to reflect on the potential impact that I could have on other people. PTs are likely to view me as an individual with power over them through my role as the leader of an educational organisation as well as my national position and profession. They suggested that I consider this and the steps that I would take to mitigate it during my research. Following this I engaged in personal reflection and conversations with fellow researchers and PT colleagues. I discovered that I had identified a blind spot. This was an area that others were aware of and I was not - as Luft and Ingham described it in the Johari window (Luft and Ingham, 1955), this is a recognised situation. Through becoming aware of it, I was able to take appropriate action. In this case by taking steps to build rapport with the PTs who attended my sessions, and also by engaging a PT colleague to come to my focus groups with me, to act as a bridge between me and my participants.

3.3 Ontological considerations

The second concept outlined here relates to the nature of the truth which may be claimed through my investigation of this subject area. These ontological considerations are of particular significance in raising key questions about the precise understanding of the reality of the phenomena under investigation and a need to establish conceptual and definitional clarity of the key terms. In this particular study, a key ontological focus will be deconstructing and developing an understanding of the term ‘professionalism’.

As I explained earlier, professionalism may be described in Pring’s terms as a “contestable word” (Pring, 2015, p.24). A contestable word is one which is broadly understood, but if asked to define the term, then differences will appear. ‘Professionalism’ is broadly understood. A glance through newspapers and magazines shows adverts engaging with the high-quality cachet of the term - for professional dry cleaning, professional builders and others who claim that they will do a professional job. This understanding of the word, or concept, differs from that used and referred to in this investigation. There is a need to be clear about the language which is being used and what it means both to the researcher and the participants in the research (Pring, 2015, p.103). The meaning of language needs to be explored, deconstructed and a contextual

understanding developed; this process of clarification is, essentially, the proposed area of research.

I have my own perception of what professionalism is and this shaped the initial frame of the research. However, as the research sought to give the cohort a voice, the participants provided their own definition of professionalism during the research process. Because my ontological stance was to unpack the PT's perspective, the approach taken gave my cohort a voice, it did not influence them to adopt mine. In my literature review I identified research that has been undertaken which seeks to gain consensus on what professionalism is (Morgan et al., 2014), test a definition (Barnhoorn and Youngson, 2014; Brody and Doukas, 2014; Moffatt et al., 2014; Paus et al., 2014) and to claim a definition (Beardsley et al., 2000; Moullin et al., 2013). These researchers adopted a positivistic paradigm. Each of these investigations demonstrated that it was essential to be explicit on the definition of professionalism that related to the cohort, but they sought to extrapolate the definition to the whole profession. I did not work within this positivistic paradigm position.

My research adopted an interpretive approach. It recognised that there are many perspectives of what professionalism means and what professionalism is, which exist concurrently. Subjective realism tells us that the reality of one perspective does not limit the reality of others (Rosenau, 1991). In this investigation, each perspective was grounded on the life experiences, knowledge and skill set developed throughout the career and practice of the individual. Each of these has value and purpose and I believe that it needed to be given a voice. Recognising that the perspective of the PT is the focus of this research is key to my ontological position. This approach was seen more closely with the work of Morrow (2011) who sought to explore the concept of professionalism for a range of health care professionals. My investigation focussed on the meaning and reality of professionalism to PTs.

My research also took a phenomenological inflection. I was trying to find out how people viewed the concept of professionalism based on their own experiences, their reflections on their lives and their perspectives. It was this conceptual framework in particular which supported my decision to use the focus group approach and subsequently one to one interviews. I was relying on

the interaction between group members to see what resonated for them, and what they each picked up on. This engagement with other people and links to personal memories and experiences based on those lived by another offered the opportunity for me to see particular significance associated with ideas, with what had been learned and what the group felt was relevant. The follow up interview offered me the chance to gain a richer awareness of the perspectives of the individual linked to the outputs of the focus groups.

In particular the focus group was a challenge as my own perceptions and beliefs were being triggered during the conversations and I needed to maintain an alertness that the boundaries of the discussion needed to be shaped by my role as a research investigator not as a participant. Challenging the group to consider how topics linked to my research and its central theme allowed me to offer them the opportunity to find and state relevance rather than for me to overlay my interpretation on their comments. For example, I asked questions such as “Tell me how your thoughts here relate to professionalism?”

3.4 Epistemological considerations

My ontological considerations have considered the nature of the truth that will be claimed and explored through this investigation. Moving on to epistemological considerations is of particular significance in addressing how the study will demonstrate that the knowledge uncovered is that intended. This supports discussions of research design and research quality. These two areas now form the two foci for my discussions of epistemology. Firstly, I consider the philosophy relating to research design and then the philosophy relating to research quality.

3.4.1 The philosophy underpinning the research design

Conceptualising the nature of the investigation is needed to provide an awareness of the objectivity of the research and thus what can be said to be known as a result. As a pharmacist I am accustomed to proving ‘things’, for example a drug is tested in a small group and the results are then extrapolated to the population. This investigation however explored a concept; that of professionalism. It gathered a wider understanding of perceptions, beliefs and values. It does not seek to say that these are representative of the whole

profession, nor to generalise, but to gain a rich insight from a few individuals. This approach is an interpretive and deductive one. Taking my habitual practice into account, the question needs to be “What does this mean for the individual?” rather than “What are the implications of this for the population?” It is important therefore that the research design empowered the individual and enabled them to share their perceptions effectively.

Pring (2015) discusses the perspective of postmodernism, which resonated with the concepts and ethos of my study. Pring (2015, p.132-133) states that it questions the positivistic ideal, questions that knowledge is indisputable and forms a base for social improvement, questions that systematic research provides solutions to problems and questions the place of teachers as providers of expertise. I think that my research fits within this postmodernist perspective, displaying elements described by Foucault (governmentality) and Derrida (hierarchies). Postmodernism offered a framework for making sense of the experiences expressed by the cohort. For the design stage it was essential that the project enabled the capture of this data. A brief overview of these areas supports this philosophical standpoint.

Foucault describes the influences of governmentality (Dean, 1999). He argues for a concept of self-governance, where an individual or group determine their own standards and then work within these. Power is seen as being positive and enabling of the individual, rather than as controlling and limiting. PTs were given a code of ethics by their regulatory body based on that of the pharmacist. They have the same regulator as the pharmacist and must submit the same number of CPD entries, to be reviewed in the same way. It may be proposed that professionalism has been exported to the PT from the associated profession of pharmacy and that the development of the PT is being controlled by external forces. The concept of governmentality proposes that the PTs may now be creating their own self-governance within this wider framework.

Further links to the postmodernist standpoint can be found when considering the existence of a privileged hierarchy (Derrida, 1981). The concept of violent hierarchies, in which the presence of one prevents the growth and development of another, could apply in the pharmacy situation. Traditionally PTs are allocated roles by the pharmacist. At the moment the PT profession is defined

and limited by that of the pharmacist. This raises the question of whether the professionalism of the PT can develop when it is so closely linked to that of the pharmacist. If the research participants could be limited by governmentality and oppressed by pharmacists, this may impact on their engagement; the investigator is both a pharmacist and a representative of a leadership body. My research needs to consider how the environment empowers the individuals.

This consideration demonstrates how the philosophical areas of axiology, ontology and epistemology are linked.

It is also important to consider the potential influences which PTs may bring to the research and the impact that this could have. The time taken to train as a PT and so be able to enter the profession is two years. When my research investigation began, there were six years' worth of PTs who had only practised as regulated professionals; those who qualified between 2011 and 2017. The latter four of these years were of students who have only known study and practice as a regulated profession. Although the evidence base indicates that the learning programme they have undertaken has not changed to take account of a new professional status, they may have a different perception of what professional practice is that would benefit from separate exploration to those who bring a heritage of high quality practice prior to becoming a regulated professional.

Appropriate approaches to explore perspectives include focus groups, interviews and case studies. I selected an approach which uses first focus groups and then one to one interviews. The merits and limitations of this will now be briefly discussed to outline why these methods were selected.

3.4.1.1 Focus groups

The focus group allows the sharing of thinking, perspectives and ideas, with participants able to explore each other's responses verbally, adding to these and clarifying them, or developing them in line with their own beliefs and concepts. This social interaction (Gibbs, 2012) supports the "synthesis and validation of ideas and concepts".

Stewart and Shamdasani (2014, p.102) explain that focus groups offer the researcher the appropriate route to undertake “an in depth exploration of a topic about which little is known”.

This concept is described further by Krueger and Casey who state that focus groups are designed “not to infer but to understand, not to generalise but to determine the range, not to make statements about the population, but to provide insights into how people perceived a situation” (2014, p.3).

These three fundamental outputs of a focus group approach permit the concept of professionalism to become that owned and described by the group rather than that of the researcher. They support me in understanding perspectives and determining the extent to which they are held by group members themselves. However, focus groups do not make it easy for the individual voice to be heard which was important for me to gain an awareness of how understanding professionalism impacts on the working practice and engagement with ongoing development for PTs. This insight was gained through an in-depth interview.

3.4.1.2 Interviews

The in depth interview is a “purposeful interaction in which an investigator… attempts to discover and record what another person has experienced, what he or she thinks and feels about it, and what significance or meaning it might have.” (Mears, 2017, p.183) This gives access to the narrative behind the accepted stories people tell themselves about their lives.

The challenge with the interview was managing to gain the answers to the questions that are central to my research, whilst also ensuring that the interviewee has the scope to explain why issues were significant for them. Pring (2015, p.53) explains that “the interview will normally only be semi-structured because otherwise there would not be the scope for those interviewed to expound the full significance of their actions…The good interviewer is able to draw out from the person interviewed the deeper significance of the event.”

3.4.1.3 A two-stage approach

I adopted a two-stage approach in which the focus group explored wider perspectives on practice and in-depth interviews added to this as they invited sharing of individual stories of PT’s journeys through professionalism. The

approach engaged PTs in thinking about, discussing and sharing their perceptions and what this means for their engagement in ongoing learning activities: it helped the researcher become less ignorant (Wagner, 1993). Together the two chosen approaches explored the wider context of professionalism for the PT and gained specific stories which helped to aid understanding of the meaning of professional practice for this group. This is part of the assurance of quality in the research.

3.4.2 Philosophical considerations relating to research quality

It is relevant to consider the philosophy underpinning the trustworthiness of research. It is widely accepted that research is trustworthy if it is able to demonstrate that it is valid and reliable. However, depending on the paradigm within which the research is situated, there will be differences in how validity and reliability are understood and evaluated.

Research undertaken in the positivistic paradigm demonstrates its reliability through being able to prove accuracy and reproducibility. It seeks to show that if the described method was followed again then the same findings would result, using statistics and error ranges for this purpose. It seeks to demonstrate its validity by making a clear and reasonable interpretation of what the results show; clarifying what it considers to be proven and what it considers to be inferred. In contrast, research undertaken in the interpretive paradigm is not able to demonstrate its reliability or validity through these approaches. It does not seek to show that it is reproducible; participants are not being encouraged to conform in their comments or responses.

McIntyre claims that the purpose of research is to “interpret or explain phenomena” (2005, p.360) with good research relying “heavily on explicitness and demonstrably rigorous rational argument”. Pring (2015, p.171-172) however states that quality comes through “thinking philosophically” and in “thinking about an appropriate method.”

For this research, rigour comes not from proving that all PTs agree, but that all members of the cohort are able to have their voice heard, whilst making explicit the recognition of the potential bias brought in by the researcher and ensuring that an analytic approach was adopted. This provides credibility for the methodology.

Alongside this credibility is the need to demonstrate validity. Two aspects through which work in this paradigm demonstrates validity are described by Wilson (2014) as democratic validity and catalytic validity. It describes the views of the wider participant cohort and uses these to stimulate change and development of the cohort. The in-depth interviews remove bias in order to reduce the impact of the researcher as described by Hantrais (2009). This is an element of triangulation; it sense checks the theming that I undertook and enables the introduction of further concepts linked to the meaning of terms set within the context of the practising PT perspective, for example from their code of ethics.

Olsen (2004, p.103) comments that triangulation is “not merely validation but deepening … in understanding”. Using this approach, it can be seen that this investigation has three viewpoints. Firstly, mine as the investigator, secondly that of the focus groups and thirdly that explored within the interviews. She further explains triangulation “thrives on the contrasts between what seems self-evident in interviews” and other methods of investigation and analysis (2004, p.4).

The quality for this research study comes through the credibility of its methodology, recognition of the potential bias from the researcher and seeking triangulation through a two-stage process and reference to the context of PT practice.

3.5 Conclusion

This chapter provides the philosophical framework that underpins the research itself. It summarises my personal impact as the researcher, my drivers and background and links this to the development of the chosen area of exploration, recognising how this can impact on the interpretation of the findings. It addresses the nature of the qualitative research being carried out, with the interpretive phenomenological approach being appropriate for the research questions being addressed. It explains how the approach of focus groups followed by interviews is an appropriate method in which to gain answers and insight from research participants.

The next chapter details the process by which the research was undertaken

Chapter 4 Method

In the previous chapter I explained the philosophy and rationale for using focus groups and interviews for my investigation. This chapter describes how this work took place, leading to an exploration of the views and experiences of PTs working in community pharmacy. It explains where participants came from, how focus groups and interviews were facilitated, the technical practical elements of recording and transposing and the theoretical structure underpinning analysis of the findings.

4.1 Recruiting participants

Previous research into PTs and professionalism had failed to engage with those offering community pharmacy services. This research is novel as it is the first to engage with community PTs and to explore their perceptions. This emancipatory driver is key for PTs to own their lived experiences and participate in research about them, their perspectives and their roles. This requirement drove the inclusion criteria for participation in the study.

CPPE holds a database of email addresses for PTs in England who have given explicit permission to be invited to participate in research related to the business of the organisation. In total around 18 000 PTs had registered with CPPE and have shared their details for this purpose, of which 7000 listed their area of practice as community pharmacy. These email addresses were used to inform PTs of the investigation and to seek their engagement.

This study held four focus groups in different locations with four to eight participants at each focus group. This ensured sufficient members to engage in active conversation and to gather a range of perspectives and backgrounds. Four locations were selected based on organisational knowledge of higher densities of engaged PTs; effectively choosing the locations where the highest number of PTs attended learning events. An email explaining the purpose of the study and asking people to contribute was sent out to all PTs within the selected geographical location. A single repeat email was sent out where it was not possible to recruit from the first email. Additionally CPPE work closely with employers within the community pharmacy setting and I asked regional

managers within the multiple groups (for example Boots, LloydsPharmacy) to share the invitation with their PT employees within those geographical locations.

Any individual who was current in their registration as a PT and working in community pharmacy in England was eligible for inclusion in this study.

Anyone who was not a registered PT, or who was a PT but was not employed in community pharmacy in England, was excluded from this study.

In total 24 PTs were recruited across four different geographies, representing London, a city, a large coastal town and a smaller market town.

4.2 Developing the focus group framework

The first stage was to run four focus groups in order to explore concepts of professionalism. My literature review used the framework of professional socialisation (Weidman et al., 2001) to underpin the development of a narrative relating to PTs and the expansion of their roles. Using this provided a structure that supported the aim of my research and so this structure was used to formulate the initial framework of questions to support the focus group conversations.

The framework explored different aspects, such as the decision making process to become a PT, growth and development within the role, impact of other professionals in terms of facilitating learning, perceptions of society on the validity of their professional status, required learning to commence practice and engagement with ongoing learning and development. I also included elements that looked at changes of self-perception linked to regulation and what the place and purpose of regulation was.

Each focus group was scheduled to last for a maximum of 90 minutes on a weekday evening after work and was held in a venue that CPPE had used before for training purposes. This was to ensure acceptability of the venue for participants and in line with my ethical approval (Appendix one) with timings based on knowledge of this being the preferred time for PTs to engage in meetings from experience of leading training events on different days of the week and at different times. I facilitated the focus groups with support from a PT colleague.

As I wanted to specifically explore concepts relating to CPD, I included specific questions about this and what helped or impeded engagement with this.

Active facilitation of the sessions avoided a question and answer approach. The facilitative approach which was used made sure that the conversation flowed naturally and invited participants to reflect on how their perceptions and comments related to the concepts of professionalism. The framework for the focus group is included in Appendix Two. The plan with the framework was to provide an aide-memoire for my own use to support the development of dialogue throughout the session. It offered both flexibility and consistency across the focus groups.

Although the framework was used across all focus groups, it provided an outline structure to guide the discussions but did not restrict the flow of the dialogue; a semi structured approach was used. This ensured that issues which were important to the PTs themselves could be surfaced and discussed and so key concepts from their perspective were explored.

4.3 Developing the interview framework

When I had held all of the focus group sessions I was able to develop a broad framework to develop an outline schedule for the interviews. I read through the focus group transcripts and identified a number of key themes that I wanted to explore in more detail through the interviews. To test the validity of my perspectives, I asked each participant to comment on what I considered to be a key theme and invited them to share examples from their own experience that either supported or refuted my perceptions.

I used the eight interviews to probe more deeply into aspects relating to professional identity, looking specifically at concepts relating to ongoing engagement with learning and development and the barriers or affordances to this. I explored what Lave and Wenger (1991) term communities of practice by inviting the participants to reflect on how they had learned from and with each other, observing behaviours and developing a shared sense of identity. This legitimate peripheral participation brought different opportunities for role development and enhancement.

As with the focus groups, I used a semi structured approach for the interviews. Each of the interviews asked a common set of questions, but I responded actively to the different accounts that were shared to add depth and richness to my findings. This approach ensured consistency and flexibility so that each of my interviewees had the opportunity to expand on areas of interest and relate the concepts shared across the four focus groups to their own practice. Essentially the interviews returned the preliminary data from the findings to the participants and invited them to expand, correct and comment. The outline schedule for the interviews is included as Appendix Three.

4.4 Ethical issues raised by the research

4.4.1 Impact on the participants

Any research which uses participants needs to consider the ethical aspects of the impact that this could have on those individuals. These considerations include how the topic being discussed could impact on the individual, whether personal or difficult topics could be surfaced during the research and how much time each individual is being asked to give.

Professionalism is a topic which is unlikely to cause embarrassment for participants although there was a chance that aspects of poor or dangerous practice could be shared. It was therefore important that all participants were aware in advance what action would need to be taken in this situation. It was stressed that people could leave the focus group at any time if they wanted to and that they didn't need to give a reason for this.

The focus groups were held in the evening after the working day and I provided light refreshments at each of them to make sure that the basic needs of nourishment were met.

From the pilots I had calculated that the focus group would last for a maximum of 90 minutes and the interview would last for around 30 to 45 minutes. All of the focus groups were held in meeting rooms at hotels to make sure that the rooms were accessible and in public buildings, but offered privacy for the conversations. All venues were easily accessible by public transport as our

organisational experience of enabling PTs to attend evening learning events had shown that this was essential.

Three interviews were held in hotel meeting rooms and five were held by telephone, depending on the preference of the participant.

All participants were informed of this information in advance using a letter and information sheet (appendices four and five) so that they could make an informed choice about whether to participate.

In recognition of the time that people were giving up for the focus groups and interviews I gave each participant a shopping voucher as a token of thanks. As PTs may be low paid workers in receipt of some benefits, this voucher was not a payment for time.

4.4.2 Anonymity and confidentiality

At each focus group participants could see who else was present and shared their perspectives and discussions with them. The focus group used a set of ground rules that asked the individuals to respect the confidentiality of the other group members and not to attribute comments to individuals after the event.

I recognized that a participant could share information that suggested unsafe practices or risk to patient health although this was an unlikely event. I explained that the need to safeguard others takes precedence over the need to assure confidentiality. If this had occurred then I would have discussed this with my supervisors and encouraged the individual concerned to take the appropriate action. It may have been necessary however to report this to the regulator or appropriate authorities. A statement to this effect was included in the information sheet.

4.4.3 Power balance

I discussed the power balance of my research with my supervisors to gain from their experience and perspective. I am a pharmacist and a leader within the profession. Both of these aspects could have resulted in participants feeling pressured or impacted on by perceptions of power. I asked one of my colleagues, a PT, to join me for the sessions to mitigate this power imbalance. She worked alongside me to build rapport with participants by, for example

discussing her own growth and development as a PT. The use of informed consent ensured that there was no coercion.

4.4.4 Data and research governance

All data files were stored on university servers or encrypted data sticks.

All stages of this work were discussed with my supervisors who are highly experienced in conducting research with participants through focus groups and interviews. I discussed my plans with them before commencing so that they could guide me in potential risks and the steps that I could take to mitigate these. For example when a PT who worked in hospital pharmacy attended my focus group, having travelled some distance to attend the evening, we discussed my decision to let her participate; she had just moved to work in the hospital dispensary and was keen to share her perspective on community pharmacy practice.

Ethical approval was obtained with a reference of AREA 15-157 and this is included as Appendix One.

4.5 Piloting, review and revision

4.5.1 Piloting the focus group

The pilot focus group consisted of eight PTs who worked together in a hospital pharmacy department in the Midlands. This focus group tested the understanding of the broad questions, assessed the links and flow within the framework and determined whether the overall approach felt comfortable for the participants. I used a group of hospital PTs as they were specifically excluded from my research cohorts, had volunteered to participate and were co-located so the time that they were taking from their personal lives was minimised. No data from this session was recorded or included in the final research piece. This session went well with the conversation flowing freely and all members of the group participating actively and finding the topic of relevance and interest. I started the pilot by asking each individual to tell me their name and how long they had worked as a PT. This introduction proved to engage all members of the group as well as providing useful information for me as a researcher and so I revised my schedule to include this as the starting question. My long

experience of facilitating events proved to be effective in nurturing conversation between participants and this shared dialogue and ownership of the topic enabled the gathering of rich data. The pilot proved the concept of the focus group approach as well as enabling the sense checking of the framework.

I discovered at the pilot focus group that my PT colleague who was there to help build rapport was keen to participate actively in the conversation so I used our feedback and debrief to stress that the focus group needed to be driven by the participants and their opinions, not by ours.

4.5.2 Piloting the interview

I held a pilot interview with the PT (PT1) who led on our learning development for this group of professionals. She had attended the focus groups with me so was able to bring not only her personal perspective to the interview but also her knowledge of the cohorts who had attended the focus group sessions. The pilot went well with PT1 understanding the questions and engaging fully in sharing her own perspectives on the outcome of the focus groups.

I discussed this with my supervisors afterwards and recognised that the unique knowledge of PT1 may have resulted in her engaging to a higher level than future participants would be able to. We looked at the general schedule and agreed a slight reworking of the questions. These changes resulted in a logical flow for the framework which started with reflection on the prior conversations, moved to exploration of the findings from the focus groups and then enabled a shared discussion over the themes and the perceptions of the interviewee.

4.6 Focus groups – logistics

Four locations were used for the focus groups. These locations considered different geographies and included London, a coastal town, a midlands town and a midlands city. This offered a range of large and small cities, industrial and semi-rural environments to provide a spread of working practices and experiences.

Although I had a framework for the focus groups I allowed the group to determine the direction of the conversations and used the framework to probe and re-engage people with my research subject. When I felt the conversation

was going off track, I asked participants how they felt their discussion related to professionalism and moved to a new area from my framework if appropriate.

I used my many years of experience in facilitating groups to build rapport with participants and to ensure that all members of the groups were given the opportunity to contribute. This was through a combination of approaches. Each participant had personal airtime at the start to share opinions and I actively invited contributions from people who were quiet, or when any one member seemed to be dominating the discussion.

4.7 Interview – logistics

Eight interviews were undertaken by phone or face to face depending on the preference of the PT. I agreed a mutually convenient time with each individual and emailed them a reminder copy of the information sheet beforehand. The interview was constructed to facilitate a dialogue between me and the participant; it was not an interrogation. This allowed me to share my perceptions and invite my participants to let me know the extent to which my ideas resonated with theirs. It offered them the opportunity to provide examples from their own development of how my theming linked with their personal development as a PT. For example, I asked the PT to tell me about their development in the role. For most participants this resulted in a wide-ranging conversation with examples from their own development linked to colleagues and specific incidents being shared. Where my cohort were not clear of the meaning of my question, the semi structured approach of my interview ensured that I could offer different phrasing of the question. For example, when one participant asked what I meant about their development in the role, I used alternatives such as “Do any incidents stand out for you, when you were not sure what to do?”

4.8 Recording sessions, review and field note comparison

Sessions were recorded initially using two digital voice recorders in different places of the table to improve potential for voices to be recorded fully and to try to resolve issues with quiet voices or background noise. I also took field notes to explore occasions when people paid particular interest or to remind myself of comments or points to refer back to during the focus group to limit assumptions that I made based on my own interpretation, or to trigger my memory later for my own reflections and perspective. As a third reference source, my PT colleague also made field notes.

After a technology failure at the first focus group resulted in some data being lost, I then used two digital voice recorders, a Dictaphone and a mobile phone voice recorder at all subsequent sessions. This demonstrated the benefits of two facilitators taking field notes; the adaptations to use different recording devices at subsequent sessions ensured no further data loss.

Each focus group was followed by a conversation with PT1 to compare our field notes, explore whether we had taken different things from the conversations and to refine the approach for the next focus group. This meant that each focus group was slightly different in its structure. As they were largely driven by the participants, each focus group also took a different priority in the area that the cohort chose to explore.

4.9 Transcription

All recordings were transcribed verbatim as soon as possible and practicable after the focus groups. After fully transcribing the first focus group myself, I used a dedicated university transcription service for subsequent transcripts. This ensured that the confidentiality of the cohort was maintained and that accurate and rapid transcripts could be provided for me to read through, reflect on and theme. I listened to the recordings as I read the transcript to address omissions and uncertainties and to immerse myself in the data again. I then read through the transcript with the recording playing in the background to reengage myself with the conversation and to highlight particular issues relating to people's reactions and their thought processes.

4.10 Approach to analysis of findings

Framework analysis is a recognised and validated technique to understand and interpret qualitative data. Initially described by Ritchie et al (1994), it has been further refined and Parkinson et al (2016) describe five stages to this approach, offering a flexible, rigorous and pragmatic approach to data analysis which permits analysis of both a priori and emergent data. Attride-Stirling (2001) considers there to be three broad stages to analysing thematic networks and six steps, there are five stages to Ritchie and Spencer's approach which are interconnected. I found these had much in common and that Ritchie and Spencer's approach worked in my analysis at each stage except for charting the data. At this stage, Constructing Thematic Networks, as described by Attride-Stirling (2001, p.391), offered a better approach. Here I explain my approach for each of these five stages which is summarised in table 3 on page 69. An example is included in Appendix Six.

4.10.1 Stage one – Familiarisation with the data

After transcribing the first focus group myself, I used a University approved secure transcription service for the remaining focus groups. My first stage of data analysis was therefore to immerse myself back in the data itself. During this stage I read through all of the transcripts repeatedly, sometimes with the voice recording playing at the same time, to remind me of the emphasis placed by participants on the content, referring back to the field notes made during the evening and the comments from PT1, the colleague who attended the groups with me.

4.10.2 Stage two – Identify a thematic framework

After familiarising myself with the data I then started to look for common issues, themes and concepts which my participants felt important and grouped these into categories, finding a common story, and giving a provisional title; it was possible for the same text to be included in more than one category. If the text did not fit into a common story I considered whether it was an outlier, or indicative of a story that I had not previously identified. The transcripts were then reviewed again to look for text that had not been linked to a provisional category to capture any unexpected issues or comments.

Some of the categories were determined by the questions that I asked during the focus groups, for example what is professionalism? Others were emergent areas that I had not anticipated, for example lack of planning to become a PT. Although the categories that arose from my direct questions were deductive, most of the categories that arose emerged during the exploration of the data and so this was primarily an interpretive approach.

4.10.3 Stage three – Index the data

I used NVivo™ to index the data, allocating the text to the different categories that I had identified in the second stage and using these as common nodes across the four transcripts. I then read each transcript again, considering whether any text fitted within one of these nodes that I had not previously recognised. There was inevitably a degree of overlap between stages two and three.

4.10.4 Stage four – Charting the themes

I worked through each of the nodes and summarised the key points that these identified. NVivo™ enabled these to be viewed by location or theme, which offered the opportunity to identify themes that were common to all locations or largely arose from a single venue.

In this stage, I was essentially pulling the data out of its original context so that I directly compared and contrasted data across the different sources.

4.10.5 Stage five – Mapping and interpreting/constructing a thematic network

In this final stage, I looked at how the different broad themes that I had found were related and linked to each other and, in some cases, combined themes to form a broader or global theme. I then reviewed these stories, themes and issues in relation to the research questions that I had formulated. Having identified these global themes and sub themes, I moved on to develop an interpretation of the focus group conversations which could then be related to the relevant research literature. This enabled me to build my understanding of the perspectives being offered through the focus groups and thus to start my interpretation of the meaning of the conversations.

Taking this structured process to analysing my data helped minimise any bias or selective interpretation of what the data may mean. Inevitably some bias has taken place at this stage since I have selected the stories through reading the transcripts.

Initial questions asked during the focus groups were intended to set people at ease and gather basic data on who was participating in the conversations during the evening. These questions generated new and unexpected information from participants and proved a good stimulus to engage with the deeper and more complex stories that emerged later in the focus groups.

Active engagement from the group members, commenting and building on each other's ideas supported prioritisation of themes. In this way the framework analysis gained from the active facilitation of the focus group process.

After undertaking this analysis of the focus groups, it was important for me to re-engage with PTs who had attended the sessions to determine whether they felt that my interpretation was a fair representation of their thinking and recollection of the sessions. If our opinions converged then this would suggest that consensus existed on our perceptions and a common reality was being shared. (Blaikie, 1991). I had undertaken four focus groups with over six hours of recorded transcripts and it would not be reasonable or fair to ask PTs to review entire transcripts or my broad findings as part of this process. To make sure that they were not asked to take too much time in this conversation, the content of the interview was narrowed down to explore three broad areas in more detail. These considered key themes related to my research questions and also picked up on what I felt to be the most surprising finding from the focus groups – the lack of planning to become a PT. The perceptions of the PTs themselves on this finding would offer additional insight.

It was also an opportunity to explore the extent to which participants had continued to think about the topic of professionalism since the focus group conversation and whether this had in turn triggered new considerations or concepts that they wished to share.

Table 3 - Process and purpose summary of method of analysis

Stage	Process	Value
1	Familiarisation with the data	This step was essential to provide a workable version of the focus groups and interviews
2	Identify a thematic framework	This stage allowed me to immerse myself in the data and identify repeated themes
3	Index the data	Using a common framework to annotate the transcripts enabled me to compare and interrogate each transcript
4	Chart the themes	Comparing and contrasting themes showed how these related across locations and sessions
5	Map, interpret and construct a thematic network	The final stage was to collate the key themes that I had found through annotation. This allowed me to identify the priority themes

4.11 Constructing the interview schedule

My initial project plan had been for the interviews to validate the focus groups and to confirm that my analysis and interpretation of the data was correct and resonated with PTs. The purpose and focus of the interviews shifted during the research process. I found that the key themes from the focus groups, which had been unexpected, would benefit from additional discussion and consideration. For this reason the interviews became an opportunity for me to start to discuss these issues in more detail and so gain a richer insight to the areas which had surprised me, or where I had not recognised during the focus group that a theme had been raised which would benefit from additional exploration. As this was exploratory work adopting an interpretative approach, this was a justified way to gain greater depth and insight into the issues that emerged as important to participants. It also offered validation that my interpretation of those issues was correct.

The final outcome was that the interviews offered me deeper insight and a more thorough understanding of the experiences and perceptions of PTs about how they moved into the role and developed their professionalism in practice and behaviours.

Consequently my interviews sought to learn more about three areas:

1 – the unexpected finding that PTs did not choose to become PTs.

2 – being a professional (what are the activities of a professional)

3 – the status of being part of a caring profession (what are the attitudes of a professional)

I invited all of the participants from each of the four focus groups sites to engage with the interviews. I did not use any additional selection criteria at this stage and interviewed all eight of the original focus group participants who volunteered to take part; two being present from each of the four sites through serendipity.

The interview conversations varied in length from about 25 minutes through to 45 minutes. Most interviews were around 35 minutes in length.

At the start of each conversation I asked if they had talked about the research with anyone since the focus groups, whilst recognising that they would have respected the confidentiality aspect that we had agreed. All but one of the interviewees commented that they had talked about the focus group with at least one person. In three cases they had used the conversations from the focus group explicitly to talk with pharmacy colleagues about what it meant to be part of a profession and to work in a professional manner. This supported my finding that participants were interested and engaged in thinking and talking about professionalism as it related to their practice.

As I initially worked through the interview transcripts, I was exploring the deeper stories and insights of individuals that provided an opportunity to explore in greater depth the stories and insights of individuals on a range of issues that had surfaced, surprised me and engaged me from the focus groups. This stage of my research started to unpick what PTs perceived and felt about these topics rather than a search for general themes.

In my subsequent exploration of the interview transcripts I again used a coding and theming approach to identify common perceptions and areas across the participants. Having analysed my findings in this way I realised that the first area which I had discussed with PTs related to relatively objective considerations, which were individual to each of them; how had they become a

PT. Since my conversations in this area had determined a lack of commonality in their approaches, I decided it was more appropriate to present these findings on an individual level.

The second two broad topics which considered activities of a professional and attitudes of a professional I collated in the same way I had for the focus groups, identifying broad themes and subtopics. An example is included in Appendix Seven. As these two approaches differed, they are discussed separately below depending on whether I am describing individual or collective responses.

4.12 Themes from the interviews

I followed the same process of framework analysis used in the focus groups for the interviews. This developmental process from categories to nodes to themes and then global themes is summarised in Table 4.

Table 4 - Coding and theming progression for interviews

Categories	Nodes identified	Organising themes	Global themes
Showing you are professional	Dressing smartly Not about how you look Need to look right What patients expect	Expectations	Essential attributes of the PT
	Need to record CPD Regulation Mandated	CPD	
Management	Have to manage others Lack of training Managing upwards Unprofessional behaviours Focus on customers needs	No training for this Conflict with pharmacist Expectations and responsibility	
Confidentiality	Need to maintain confidentiality Everyone does it Enduring responsibility Duty to patients	Qualification doesn't enable the role	
Role	Patients with problems and needs All parts of society Advising experts	Open and engaging Building rapport	Focus on patient care
Care	Can't just walk away Expectation of ability and competence Responsibility	Burden of care Innate desire to help	
Excellence	Being the best you can Listening properly Assuring standards Doing it right Being accurate	Innate desire to improve	
Keeping up to date	Always learning Part of daily practice Enables the role Patient safety	Drive to improve	Engagement with learning
	CPD Regulation Revalidation	Required to learn	

4.13 Summary

This chapter described the logistics of the research. It explained how participants were identified and recruited for both the focus groups and the subsequent interviews. It described the broad geographical regions and differences in urban balance that the focus groups were held in and how data was gathered through recording, checking, transcription and interrogation.

The nature of the data being gathered resulted in ongoing revision and development of the questions that were explored and this was described as part of the iterative and developmental process.

The next chapter details who the participants were that shared their opinions, feelings and concepts and how the data was analysed and interpret to build an understanding of the data that I gathered.

Chapter 5 Perspectives of Pharmacy Technicians

This chapter focuses on the PTs who participated in my research and the data that was gathered through the focus groups and interviews. It brings these together in broad responses to the question areas that were asked first in focus groups and then as follow up questions in interviews so that the general comments and responses can be seen. Whilst this data has been collated and summarised, this chapter shares the voices of the PTs themselves, seeking in the early sections to minimise the analysis and interpretation of the data. The latter parts of the chapter move on to the analysis of the information as it is interpreted and broader concepts are brought to the surface.

5.1 Introducing the participants

Four focus groups were held in different locations across England which are described as London (L), Coastal town (CT), Midlands town (MT) and Midlands city (MC) to assure anonymity of my participants. Any comment that could have identified a participant or location has been deleted or replaced with XXXX.

This section starts with an outline vignette of the people who came to each focus group. These are grouped in the geographical areas and for each I provide a brief overview of their background and development as a PT. This offers useful and essential context for the individual perspectives that were shared within the conversations. It was a key finding that there was no one route into becoming a PT, indeed there was a marked lack of commonality in this group of professionals. This was seen repeatedly in each of the groups where I comment on different backgrounds, nationalities and routes into the profession.

5.1.1 London (L)

The four PTs who attended the focus group in London came from different backgrounds. L1 went to work in a community pharmacy when she left school, worked her way up from counter staff to becoming second in charge of the pharmacy. She had planned to become a teacher but instead trained as a PT. Subsequently, she moved to work in hospital and took over training of PTs there.

After qualifying as a pharmacist in India, L2 moved to the UK and registered as a PT; he would need to complete additional learning to register as a pharmacist in the UK. He worked as a locum PT and provided services in community, prison and hospital pharmacy practice.

L3 qualified as a PT in Ireland and was working to have her qualification recognised by the GPhC in England, a process which she described as long and complex. She was working in a national multiple pharmacy which dispensed prescriptions for hospital outpatients at a large London trust

L4 qualified as a PT after initially training as a veterinary nurse. She worked with the third participant in the outpatients' community pharmacy at a large London trust.

The decision of these final two participants to attend the evening brought into a sharper focus the changing nature of traditional sectors of pharmacy practice described on page 15. Although the two PTs worked within the buildings of a hospital and provided pharmacy services for hospital patients, they considered themselves to be working in a community pharmacy practice. New models of pharmacy practice are evolving and the community pharmacy within a hospital building is a novel entrant. The pharmacy has a contract with the hospital trust to dispense to the outpatients being seen in the hospital and a second contract with the NHS to offer community pharmacy services.

5.1.2 Coastal Town (CT)

Four of the six participants in this town worked in the same pharmacy. They consisted of two families. From the first family a mother and her son attended, from the second family two sisters. During the focus group the sisters explained that a third sister had recently joined the pharmacy team. The other two participants had taken up roles in primary care offering advice to prescribers.

CT1 was the lead PT from the community pharmacy who had been referred to pharmacy via a job centre and commented that she had never looked back. She had no prior experience of working in pharmacy, nor any comprehension of what it would involve. She qualified as a PT and now led a large team in a community pharmacy which provided a wide range of services.

CT2 said that he was brought up working in the pharmacy and never really thought about doing anything else. He now offers pharmacy services to Care Homes in the town from the community pharmacy.

The first of the sisters, CT3, went to work in pharmacy as a member of counter staff straight from school and trained as a PT because she enjoyed her work so much. She persuaded her sister, CT4, to come and work in the pharmacy, who also subsequently trained as a PT. Together they had encouraged their third sister (not present at the focus group) to come to the pharmacy because they knew that she would enjoy it. She was in the process of training as a PT.

CT5 explained that she had made a conscious choice to work in pharmacy because she believed it would be a good working environment, but she had not known about or planned to work as a PT. She first applied to work as a driver, delivering medicines to patients, and then developed within the organisation to work in the dispensary itself and finally to become a PT after she had learned more about the role. She had worked in a range of community pharmacies across the city and had recently taken a job for the NHS Clinical Commissioning Group. This role involved her advising prescribers on medicines use in line with a local formulary and in helping prescribers and practice staff understand more about community pharmacy services.

CT6 had started as Saturday girl in a community pharmacy which was part of a large national chain – commonly known as a multiple pharmacy. She trained as

a PT and had a job working in the pharmaceutical industry before moving back to community pharmacy practice where she was an accuracy checking PT. At the time of the focus group she was on maternity leave but planning to work at the CCG when she returned as she had lost her accuracy checking status through being on maternity leave. There is a requirement from many training providers of the Accuracy Checking programme that the PT has to undergo periodic reaccreditation. For this individual the reaccreditation was due at the start of her maternity leave period. Despite knowing that the PT was on maternity leave, the provider refused to consider that an acceptable reason for not being reaccredited and so she lost her status to offer this service. She planned for a role advising prescribers on medicines use when she returned from maternity leave.

These two latter PTs brought into focus issues relating to identity and the PT role. Both of them considered themselves to be community PTs. They had trained in community pharmacy, gained their experience in community pharmacy and continued to provide pharmacy services to their local communities.

5.1.3 Midlands town (MT)

The four PTs who attended in the Midlands town had all taken different routes into the role. MT1 started a part time role in the pharmacy after having children. She enjoyed the work and moved to work in dispensary. She then qualified as a PT and is now part of the lead team in a large community pharmacy practice.

MT2 worked in the same large community pharmacy practice as the first. She had worked for the police force, but needed a part time job when bringing up children. Like the first participant, she found that she enjoyed the work, so qualified as a PT and is now the second member of the lead team.

MT3 was referred to pharmacy by a job centre as she was interested in science. She enjoyed the job, qualified as a PT and went on to work as a practice advisor for the CCG. This involved working directly with doctors and nurses across the county and advising them on the use of medicines in line with the local formulary.

MT4 went straight to work in hospital pharmacy from school, training and qualifying as a PT there. She is now working in an education role leading on accuracy checking support for PTs working in the community and is planning a career move to HR and away from pharmacy.

The latter two participants in this group again demonstrated different perceptions of being a community pharmacy-based PT. They had both trained in hospital pharmacy, so considered themselves to be hospital PTs. However, since they had left that sector of practice and provided services in the community, they no longer felt that they were hospital PTs, so described themselves as community PTs. This highlighted the ambiguity and challenge for PTs in trying to describe their identity. Hospital PTs described themselves as different to community pharmacy PTs; they had followed a different learning pathway and were often paid a higher salary. Once they left the hospital and started working in the community, they found it difficult to know how to describe themselves.

5.1.4 Midlands city (MC)

The five participants in a Midlands city shared different stories again of becoming PTs. MC1 explained how she had worked in what was a local department store on the beauty counter; she progressed from the role to working in health care, starting on the pharmacy counter and then trained as a PT. She was still working in the same store, although it had changed hands.

MC2 had worked on the shop floor for a large supermarket that had introduced a pharmacy. She learned about the pharmacy and took the step of funding her own training through a local college to gain a pharmacy qualification. Having gained the qualification and worked in community pharmacy practice, she had recently transferred to hospital.

MC3 had also worked in community pharmacy for the same large supermarket as the second participant. He explained that he had been supported and motivated by an excellent manager to qualify as a PT. Like the second participant, gaining the qualification resulted in him leaving the supermarket when he took a new job at the hospital because it offered a higher salary and greater opportunities for role and career development. The two participants

commented that the supermarket had now implemented a ban on the staff that they employed undertaking the qualification to become PTs.

MC4 explained that when she left school in the 1970s she had two choices; one was to work in pharmacy, the other was to work for a local engineering firm. Her family said that working in engineering was no job for a lady, so she went to work in the pharmacy. She had stayed with the store as it progressed through different owners and trained as a PT. The store was now largely under her management, with the pharmacist service provided by locum pharmacists who differed on a daily and weekly basis. As the PT she was the point of consistency in the professional pharmacy team. As well as being a PT, she was a Justice of the Peace (JP).

MC5 described her introduction to pharmacy as unplanned. She had taken the job while looking for something else to do as she needed a wage, but enjoyed it and so progressed in pharmacy and took the qualification to become a PT. She was now engaged in teaching other PTs as they undertook formal qualifications.

5.2 Key themes from the focus groups

The thematic analysis process for the focus group data highlighted five key themes. These were:

- Routes into becoming a PT
- Learning to be a PT
- Impact of role models
- Impact of regulation
- What professionalism is

Each of these themes is now explored in more detail.

5.2.1 Routes into becoming a PT

One of the early conversation topics in the focus group, designed to put participants at ease, explored what had attracted PTs to their role. A common finding across all the focus groups was that none of the participants had actively chosen to become a PT.

> “I think if you ask most technicians they’d say it just happened, we fell into it.” L4

It was not something which they felt had been discussed at school or promoted to them as a career choice and they could not think of older friends or acquaintances who had studied to be PTs.

> “No one we went to school with was going to university to do pharmacy, it's nothing anyone ever mentioned” MT3

The reasons for becoming a PT related more to the need for employment and it being one of the positions available to them without university level qualifications. There was limited awareness of what working in pharmacy or a PT entailed. The work was simply a means to gaining employment, rather than a way of developing particular knowledge or skills.

> “I didn’t know anything about pharmacy. I'd left school, didn't have a job, and was sent by the local Jobcentre, there's an opening for a counter assistant in this pharmacy. I didn't know where it was, I looked on the bus going home, as to where it was, and didn't even know that part of the road existed, so I wouldn't even have gone to that pharmacy.” CT1

Others had applied for jobs in a local pharmacy as a way of getting part time work in later life so that they could be around for their young families. It was the perceived flexibility and location of the job, rather than the nature of the work itself, that attracted the applicants.

> “I wanted a job that you could go into, work your hours, come out of” MT2

Some participants talked about drifting into the role after taking a retail job in a store which later offered pharmacy services. Although they saw the move as a positive step, they had not consciously sought the challenge.

> “You get more challenged, and so you start taking on more other work. And we ended up here. So, yeah, it wasn't a career plan” MC4

There were instances where individuals had worked in other professional areas, for example the police force, the judiciary or in teaching, before becoming a PT.

Others were referred to the pharmacy when looking for work and using job centres.

> “I must have applied for 40 jobs, and that was the 41st job, and I applied for it, because it had the word technician in it. And I knew that I was a scientist, and I wanted to pursue sciences, so I applied for the job, and got it.” MT3

Although the common story was that people didn’t choose to become PTs, this was followed up by satisfaction in the role and a recognition that they enjoyed the job and were glad that they had taken it.

> “And here I am, I’m loving every single day. I’ve been here nine years and I’m still loving it.” MC2

There was no common route into becoming a PT which was shared by participants in any part of the country. The underlying theme was of a complete lack of public awareness of the role, it was not talked about in career planning discussions at school and was not known about as a position that was available within the pharmacy team. Working in a pharmacy was seen as a positive thing, but the work that was undertaken within the pharmacy was not common knowledge across the wider community. In the Coastal town, the younger PTs had been told about working in pharmacy by parents or siblings and had been encouraged to join the profession. Later conversations showed that these PTs felt that they had a good employer, but the role of the PT retained value even when an employer was described in less favourable terms, as in an MC discussion relating to a large supermarket.

This lack of planning to enter the profession did not mean that PTs considered it to have been a bad move. None of the participants expressed any regret about being a PT, instead expressing their pleasure in having learned about the role and sharing their enjoyment of undertaking a role which they felt to be fulfilling and adding a value to patient care. There was a sense of pride in their position and status.

The PTs also talked about there being a need in the future to reach out to children and school leavers and to let them know about the profession and the opportunities it offered. As a profession develops, perhaps there is first a need

for it to create its own sense of identity before it is possible for others to identify with it in this early stage of professional socialisation. And perhaps that is what those who came to my focus groups were starting to think over and plan to engage with.

From the PTs conversations however it was clear that age was not a barrier to joining the profession. Whilst some of my participants had entered the profession as their first job after leaving school and had then stayed within it, for others it was a later life choice. They chose to become PTs as a way to earn some money with part time hours in a place near to where they lived. In this sense they believed they were getting a job in a shop and then discovered after starting that it was different to other shops within their community. There was no suggestion in the conversations that it was this sense of difference which had appealed to them – even though this was commonly known with the mother of one participant having commented that

> "You will have to keep yourself clean now" MC1

on discovering that she had gained a job in a pharmacy.

This ease of entry to the profession at any age seemed to have been one of the key factors that encouraged people to apply for the jobs. As the PT profession was the only one of the health care professions which did not require degree level education to enter the profession, this may be a key factor to consider and bear in mind.

The other thing that surprised me to an extent was the range of career development opportunities which some of the participants discussed. Some participants talked about a tried and trusted route of gaining the PT qualification whilst working in community pharmacy and then seeking employment within secondary care practice. Within pharmacy practice the PT can typically earn 50 to 100 percent more by moving from community pharmacy to hospital pharmacy practice and so this move was perhaps unsurprising. However, other participants talked about moving to work in general practice and clinical commissioning groups as they left community pharmacy practice. These roles used the NHS pay scales so again offered a significant premium to the possible salary in community pharmacy. One participant had moved to work in the pharmaceutical industry, again achieving a higher salary. And within the

community pharmacy setting, participants talked about taking on roles to support and work within care homes. This mobility and flexibility within the role demonstrated that the PTs recognised that they had not simply learned how to do a job in a shop, but had gained specific skills which enabled them to practice as professionals in a range of areas. And it was these wider opportunities to explore after starting in their roles that they wanted to talk with school children about to encourage them to join the profession.

The significance of these conversations relating to the serendipity associated with becoming a PT was that participants felt strongly this was something that needed to change. They believed that people needed to know about the profession and to be encouraged to come and join it. Whilst this was my understanding and interpretation of the conversations, I felt it was important to explore it further with my participants during the interview stage of my investigation.

5.2.2 Impact of role models

There was a broad range of views on the presence and influence of role models. In some cases, it was clear and a single positive role model was identified who had impacted on many people. This was particularly notable in the Coastal Town focus group, where one individual was cited as being the role model for all of the other PTs working in that practice. Participants talked about learning from the way that she worked and the instructions that she gave to them. She knew that she was a role model for her team and actively set out to be one to guide their practice and assure high quality, professional services. They recognised that she was explicit in her approach as a role model explaining that she told her team that they needed to adopt her behaviours as their own. This was the only instance of this during the investigation and so there is no evidence to claim that this is routine practice for a PT.

> “If they say to you when you're training, and you ask a question and say, come and listen to how I speak to the customer and give advice, and you listen to it, and you remember that story, that helps you to be just like them. And hopefully, you've got a good one.” CT1

Discussing role models raised a level of interest amongst the participants who tried to tease out whether they did learn from other people in this way, or if they were working with people of a similar mindset.

> “But like you say, you have got to learn it - where do you learn it, like you say. We've been lucky enough to be surrounded by like-minded people who have, like you, have done it an awful long time, obviously. And it's good to be round that. But if you were from somewhere else, would it be different?” CT3

In other focus groups, the role model was a pharmacist rather than a PT. Participants talked about the pharmacist influencing their engagement with the course, supporting them through their learning programme and qualification and acting as a mentor for them afterwards. Despite these comments coming from different focus groups and geographical areas, participants always referred to this guiding pharmacist as being “old school”. Each of these different descriptions of role model ‘old school’ behaviour was described as being a professional approach, with learning the right way to practise in pharmacy as an explicit intended outcome.

There was no link made between the age of the pharmacist and them being old school, indeed in one case the PT made a point to stress that the pharmacist in question was not old. Rather old school was seen as a traditional way of working and of meeting high standards. In each case the pharmacist had made an explicit point of asking the PT to observe and learn from their role model behaviour.

In some cases, the role model behaviour was linked to the pharmacist demonstrating how to undertake activities. The pharmacist demonstrated how to undertake the action correctly and asked the PT to copy it.

> “I think, from the first independent shop I was in, where the pharmacist took me into the dispensary, and started to show me about the dispensing prescription, because he was an old school pharmacist - well, he's not old.” MC5

> “My first week was cleaning shelves. And I thought, well, what's this to do with pharmacy? It's how you learn where the stock goes. And he was

very old school, and he taught me, and the way that he taught me is how I taught" MC1

In other cases, the role model behaviour was described as a nurturing relationship, where the pharmacist was seen as a trusted guide and mentor.

"Well, mine started off sort of quite early, at an early age, when I was a Saturday girl for one of the big boys. And I loved my Saturday job, and I believe that it's the people who mentored me there, that I started - well, I would like to think that I was professional right from the off. And then, I sort of got taken out of pharmacy, and went on different avenues, career wise. But I always came back to pharmacy, it was something that I really wanted to do, and I had the opportunity for doing my training with an independent who is very much old school. Very professional, the way that he does it, he still does it now." CT5

There was also discussion over learning from role models who demonstrated the wrong behaviours. Participants described practitioners who acted in ways they felt were inappropriate or unprofessional and commented that this taught them what not to do, so was in itself a learning experience.

"Yeah, like to go to work, and you don't know if there's going to be a pharmacist there. And then, it would be a locum who would come from XXXX so they'd travelled and they were doing a 12-hour shift. So they'd just wander around or sit and do nothing." MC4

Whilst in these situations the PTs recognised that they had learned how not to practise as pharmacy professionals, they recognised that this was different to explicitly being taught or shown what professional practice looked like. There was agreement that bad working practices, such as laziness in this case, were not associated with being professional. It was not clear what basis the group was using to decide what consisted of bad working practices and this was not explored during the focus groups.

It was important to explore the influence of role models on PTs for two reasons. Firstly, professional socialisation theory explained that members become part of a group, they identify with others within that group and set their social mores and ways of thinking in line with the behaviours and perceptions of others with

whom they are working. And secondly, I was exploring the impact of ongoing learning on people within the group and to do that effectively, I wanted to explore the extent to which the influence of role models was a factor that my cohort considered influenced their learning and development.

The impact of the role model was most visible in the Coastal town focus group where three of the participants all identified a fourth participant as their role model. They discussed the steps that this individual had taken to make role modelling explicit, telling them when she was going to demonstrate role model behaviours and making it clear to them that she expected them to adopt this approach in their own ongoing practice. This had an enduring impact on their engagement with the profession and had resulted in them actively promoting the role to others; one PT had encouraged her sister to work in the team and together they had brought their third sister to work with them. Each of them recognised that they needed to demonstrate role model behaviours for the new members of the team.

This concept of whether people were encouraged to join the profession by others because they saw something in them that made them appropriate for the role was picked up in other focus groups. When discussing why they had taken the qualification, other PTs talked about a manager who was a pharmacist who had encouraged them to apply for the course because of the behaviours that they demonstrated in their practice in other roles within the community pharmacy. In two cases where PTs worked for the same multiple pharmacy, based within a supermarket, they had self-funded their engagement with the qualification after encouragement from their pharmacist manager. The manager had recognised their ability and motivated them to engage with learning and development. And through this they had gained the qualification and started their career progression. This latter case also highlighted a clear difference in perceptions between an employer and the pharmacist in relation to multiple pharmacy practice. The employer had since banned its staff from training as PTs in order to restrict opportunities for them to progress their careers in other areas of pharmacy practice. The PTs involved talked highly of the professionalism and motivation of their pharmacist, but negatively of the restrictive practices of the employer.

Participants also talked about other occasions where they had seen behaviours which they considered were incongruent with professional practice. They explained that these had taught them what was poor practice and did not see these as role model learning opportunities. Whilst observing poor practice was seen as a learning exercise, the outcome was not explicit. They knew what they did not want to do in certain situations, but had not seen what a role model would do in that same situation. These findings support the need for role model behaviour to be made explicit so that others know that they are in a learning environment and can engage with it appropriately.

5.2.3 Learning to be a Pharmacy Technician

All participants had completed the basic qualification needed to register with the GPhC and practise as a PT in the UK. For community PTs this was typically a distance learning programme which resulted in a level 3 NVQ in pharmaceutical science. It was a work-based learning programme, with the PT expected to learn on the job and to apply the theoretical content of the programme to their work practice, under the supervision of a pharmacist or PT. Although this was the intention of the learning programmes, comments were shared by participants of a lack of connection between the taught component and the realities of the role. Some commented that the initial education and training which they undertook was not linked to their ongoing practice as a PT:

> “It were interesting to actually do it. But I did find that a lot of it wasn't relevant to what we do at work” MC4

There was recognition that the role of the PT is in a state of change and so practitioners needed to keep gaining new knowledge and new skills in order to continue to practise in their roles.

> “So, you know, there's still that learning aspect, once you have registered, that, you know, you can continue to learn and do other things as well, it doesn't just stop there.” L3

Participants talked about an element of curiosity driving their decisions to keep learning, recognising that they had an obligation to be sure that they knew about the medicines that they were dispensing to patients,

> “To better yourself, and to find out information. And to think, okay I've not used this before, what's this for? Pick up a leaflet, read it, find out what it's for. Don't just dispense it because it's on a prescription.” CT1

Some of the learning that they engaged in was driven directly by expectations from customers and patients that the PT should have expertise in the medicines that they used

> “Someone will come and ask you something, and you'll think, no, but I’ll go and find out. So, you're doing that learning all the time.” CT4

Participants also recognised that they were part of a wider team and this brought an obligation on them to have the right level of knowledge.

> “It's like the knowledge that you need, and commitment to keeping knowledge going” MC1

There was a sense of responsibility to the team and to the business. This responsibility was multifaceted, with recognition that not knowing things could harm patients as well as cause problems within the organisation.

> “It's having that level of knowledge that you know that you're the one that is acting on behalf of the pharmacist, the majority of the time. They're trusting you, because for all the responsibility is ours, if we do something wrong, it reflects on them, and they're the responsible pharmacist, or they could be the superintendent pharmacist. And it doesn't look good on the business, it could have serious repercussions for the patient, and their families. So there is an awful lot of responsibility that goes with being a technician. And I think it is misunderstood.” CT1

Many of the examples of learning needed for PTs related to management and people skills rather than to scientific or therapeutic skills.

> “You registered, and you got that extra qualification. Even though it was for technician-ing, you were expected to maybe manage” MC4

Participants talked about being responsible for the branches and stores that they worked in, for team training and for information and governance. Although this had not been covered in their initial education and training, participants felt that this resulted in the learning being more useful and that they were more likely to remember it.

> “That knowledge that sticks, as well, when you're on the job, you know, you do seem to remember it more.” CT6

These conversations started to uncover the relationship between learning and the role of the PT. Firstly it was clear that the PTs did not see that their initial education and training was sufficient for them to practise effectively in their role. They described a lack of connection between what they were learning and what they were doing, despite the learning programme being a work-based qualification. This appeared to be a distinction between the specific content of that qualification and engagement in learning itself.

Learning was described as being essential to what they did and how they fulfilled what was expected of them. They described ways in which they sought out and gained knowledge and talked repeatedly about the opportunities that they took to develop themselves. They explained that this was needed in order for them to provide safe patient care and adapt to the changing demands of pharmacy practice. This engagement with ongoing learning was described as being part and parcel of the role and just the routine daily business of being a PT. It was not something that was forced on them nor something that they considered to be a burden. This was of particular interest because later, when asked directly about continuing professional development (CPD), this positive attitude was less evident. PTs did not link their routine ongoing learning with the concept of CPD. Ongoing learning was talked about in positive terms as an enabler, CPD was talked about in negative terms and described as a burden.

The concept of knowledge and how this related to pharmacy practice was returned to repeatedly through the conversations with participants. They all recognised that as soon as they started to work in the pharmacy, they had been required to start to undertake training. For some this had been as a member of counter staff, with the progression to dispensing and then to becoming a PT taking place later. For others they had obtained the role specifically as a PT so had begun this stage of their training process straight away. There were no conversations about whether people were surprised at the level of training that was required of them or whether they considered it to just be the way that things were.

It was apparent that the training which participants received during this period of initial education and training was not closely linked to the roles that they found themselves performing in practice. The education they received was not sufficient for them to practise effectively and, as a result, they took opportunities to develop themselves in order to provide safe patient care, manage a team and engage effectively with health care colleagues. One positive outcome from this was that ongoing learning was seen as essential from the moment the PT took up their position. They needed to fill the gap between gaining the qualification and being able to do the role itself safely and competently. This learning seemed to largely take place as self-directed learning. They described accessing sources such as the BNF and medicine information leaflets to learn about the medicines they were dispensing and supplying. They referred to a need to undertake learning related to managerial skills and observing others to see how to work well with people and other health care providers. The lack of structure or commonality to this learning appeared to be an educational need. Guidance in this area is essential to ensure that all PTs recognise this need and are supported and mentored to access this learning.

It is significant that participants saw the CPD requirement of the regulator as being separate from the personal ongoing learning and development undertaken out of curiosity to improve themselves. CPD was something that had to be done, it was mandated, and it was seen as a burden. Ongoing learning was something that supported them to be better in their roles and improved the way that they worked with their teams, or the advice that they could offer to those people using their services.

5.2.4 Impact of regulation

Although PTs have been part of the pharmacy team for many years, their role was not regulated until 2011. This was the change which conferred a professional status on PTs and it was important to unpick the impact of this on working practices and identity with participants. In London and CT around half of the PTs who engaged with my research had only been working since regulation; they had no experience of being a PT prior to regulation being introduced. At MC and MT all of the PTs had been working in their roles prior to 2011.

The PTs described the impact of regulation on working practices for PTs as minor, with participants across all sites commenting, when asked what changed when regulation was introduced, that it had not really had any impact on the way that they worked. They only described two changes, firstly that you had to be on the register if you wanted to call yourself a PT

> “If you're not registered, you are a dispenser” MT4

Secondly, they now had to record their CPD. The conversations around CPD showed that they perceived this in a different way to the ongoing learning that was part of their role. CPD was linked with regulation and the value of it to their practice was not clear.

> “We just carried on the same as we were, with the addition of CPD” MT3

> “You're doing your learning 'cause you need to do your job, you do your CPD separately” CT2

For some, the burden associated with recording CPD was too much and one group spent some time discussing a member of the team on whom this had a large impact. This was an individual who had chosen to leave the register and stop being a PT. She had made this decision because of CPD and the pressures of the process.

> “She was just struggling so much, she'd had her CPD called once before, and she'd done that, when you could still send in a paper version. But since it had all become online, she was really struggling. And she decided, no, I just want to be a dispenser again, I can't handle this stress” CT1

Her colleagues considered this a sad development. They discussed how this decision to leave the register impacted on her status as a professional and started to tease out the difference in the work that was undertaken.

> “And the role she does, as well, now, is very much - the difference within dispenser and technician. We've always said, haven't we the role she's doing is just like a dispenser's role, really. And almost, we've always said, she's wasted because she wasn't using anything extra than what a dispenser could have done for us” CT4

The conversation linked to this individual brought to the surface a range of interesting areas related to being a PT and professionalism. There were four PTs from the same practice who were discussing this individual and all of them were in clear agreement that by coming off the register, this individual's place and status in the team had changed and she had given up on something. They discussed the attempts they had made to support her and encourage her to stay on the register and had found a safety net structure to give her time to change her mind. Once she had made the decision to leave the register she was seen as someone who had limited herself. She had made a decision to lose the protected title of the PT and had become just a dispenser. It was clear from the body language and comments of her colleagues that although they understood her reasons and sympathised with her, they saw it as a step down and that she had in some way diminished herself at work. They referred to her being "just a dispenser now" and "she's wasted" since stepping off the register.

All four members of the team agreed that CPD was a burden and that the experience of their colleague was evidence of the size of the burden that they managed and engaged in routinely. This displayed their own sense of pride and a different identity within the team to that of someone who was just a dispenser. It showed that they knew that being a PT set them apart and they were in some sense better as a result. They demonstrated that they recognised that being a PT conferred an additional status and that this was felt to be a positive and meaningful thing for those who were still on the register.

My conversations were designed to engage people in discussions on CPD as the routine method of engaging in lifelong learning. However, an unexpected finding from the focus groups was that all PTs described a separation between meeting the requirements of regulation and learning as a method of improvement. Conversations related to learning in practice repeatedly saw this as standard practice and part of the daily routine. CPD was described as needing to engage in learning and record it in order to retain registration each year and this was linked with being a burden. Participants reported that recording was a monotonous process that had to be done, rather than a process that enabled the individual to share innovative learning or demonstrate how their learning was part of an ongoing process of learning and development.

Although the impact on their working practices was described as limited, as conversations continued, however, participants recognised that registration conferred a certain status on them and their roles and that this brought with it additional obligations and accountability.

> “You do have a lot more responsibility, or you feel like you have a lot more responsibility, when you are registered” L3

These conversations started to unpick issues relating to the change in perceptions of self-identity after regulation. PTs knew that they were now something different, with new responsibilities, but were not sure how that related to a change in practice. When they talked about their role, they explained that this had not changed or been affected by regulation.

The attempts to describe this came to the surface in CT when the conversation drew comparisons with the colleague who had removed herself from the register described on page 92. Although her colleagues described her as doing the same job and the same roles that she had before she left the register, they discussed what had changed for her since she stepped down. This made it clear that differences were not just limited to differences in the workplace, but also that being a PT required an element of taking the job home.

> “She's not worrying about learning new things, thinking, I've got to have CPD. There's no stress there, she comes in, does her job. She doesn't have to go home and think, oh I'd better do some CPD tonight, or, what am I going to need to do tonight, what courses might I need to attend” CT3

This impact on the individual outside of the usual workplace and working practice was also apparent when participants discussed their need to meet professional standards. They recognised that the regulator took an interest in the person not just their practice. This meant that regulation had brought in an element of fear for PTs. In three of the four focus groups, PTs told stories that linked to a low-level concern that getting something wrong either within their practice or outside of it could result in censure linked to their registration.

> “I had a ticket on my car, first time in my life, and first thing which came to my mind was are they going to strike me off the register. Although

> they're not, but because that was the first time I'd ever had a ticket and I was a registered PT I got so scared. So that actually does create a little bit of a thing in your brain. It controls your behaviour a bit… I'm more alert that any of my actions, anything I do, it can be challenged and anything I do can actually get me striked (sic) off the register. You could lose your job for it. Now I'm extra conscious" MC2

These conversations showed that although it was not seen as an explicit change to their practice as a result of regulation, there was a recognition of the different ways in which they viewed themselves both within the workplace and throughout their lives. PTs knew that their behaviours were being shaped by the requirements of their regulator. It was reasonable to assume that their personal identity was being shaped as well, even though they were not fully conscious of this.

At the time of this research, being regulated was one of the essential elements for a group of individuals to be able to claim status as a profession. For PTs, regulations defined both the knowledge that was needed to enter the profession and the ongoing standards that had to be met. PTs were required to register with the GPhC in 2011, a key step for their recognition as a healthcare profession. When regulation was introduced by the GPhC it was heralded by the APTUK as a good thing for PTs as it cemented their status as a professional group (APTUK, 2016). There was both support for this concept and recognition that it was not always a positive thing. PTs working in the community setting have a lower salary than those working in direct employment of the NHS; this was the reason provided by participants in the Midlands city for their decision to move from supermarket employment to the local hospital. Registering as a PT with the GPhC had a price, there was the cost for initial entry to the register and an annual cost for renewal of registration and revalidation. PTs had to engage in ongoing learning and development and, although learning resources were available at no charge to the learner, there was still a need for the PT to travel to the venue for face to face training and give up their own time to undertake the learning exercises.

There were also links with a change in status for the PTs as a result of registration. They had a sense of pride in the name and the title amongst

themselves, although they felt that this was not recognised in wider society with some participants saying that they described themselves as ‘from pharmacy’ rather than as PTs. The sense of status underpinned their self-belief in other areas of their life. One PT described how her professionalism was equally as important when she was teaching roller skating classes or working as a JP. Another talked about the responsibility that she continued to have towards her patients even when she was not at work.

> “I do live in the village, I always want people to know that whatever they say is confidential. Because I live in the village, do you know what I mean, I can't explain it any other way” MT2

Whilst regulation was not highlighted by my participants as either a good or a bad thing in itself, it was clear that they knew that regulation was what entitled them to use the title of PT. These conversations about the difference between a PT and a dispenser started to highlight the concept of professionalism and provided a way to begin talking about professionalism. The regulator required pharmacy professionals to work within nine standards (Figure 3, page 34) and it was clear from the conversations with participants relating to regulation that they were aware of the wide spread of duties that related to their registration and its impact on their practice. Although being a professional was seen as offering a sense of prestige to their roles, they did not describe the regulator as a positive force or influence on their practice.

5.2.5 What professionalism is

As it was the core of my research project, I started and finished each focus group by asking all of the participants to tell me what they thought professionalism was. The findings confirmed the lack of consensus and elusiveness of the definition within the literature. Although there was little difference between the content of the responses at the start and end of the focus group, the summary descriptions of professionalism were delivered with greater confidence and an acceptance that they were members of a profession.

There were three broad domains outlined by PTs. These related to quality of work, responsibility for customer wellbeing and being a representative of a wider community

Quality of work is widely seen as the marker of professional work and this is the context that underpins adverts for 'professional service provision' in common media. PTs described this in terms of the way that they would talk with patients and the requirement to make sure that they dressed in a way which was in keeping with being part of a quality service. These were very simple markers and, although they were described as essential, this was not what made them professional.

> "I can't just be going to patients and saying hi babes, are you okay" MC2

As the conversations progressed however, they talked about wider issues linked to duty, obligation and responsibility – even if this was outside of what they perceived to be their accepted role.

> "If you see something that could potentially harm your team and the people above aren't doing anything about it, can you honestly say it's not your responsibility to take on?" CT1

Professionalism was also considered to be a way of behaving and it applied to any individual, not simply to those who were members of a profession. The group talked about professional behaviours being the high standard behaviours and approaches that people could demonstrate in any job.

> "Professionalism is how you deal with that job you do" L3

This concept of professionalism as a way of behaving was not something that PTs discussed as being unique to them or a responsibility that was specific to their role. At each of the focus groups, PTs referred to different groups of people who worked as professionals and used them as a comparator group to show that this was a common way of working for professionals.

Different examples were used of behaviours that showed professionalism as a sense of care. For example bin men were used as an example if they returned the bin with care to the home that it came from. They were displaying unprofessional behaviours if they simply left the bin at the side of the road. This showed that the PTs knew that working in a professional way needed more time, more effort and active contemplation of the needs of the customer.

However this ability to work in a professional way was seen as being different to working as part of a profession. Teaching was used as an example to unpick this concept. PTs discussed the fact that if one teacher did something wrong, then the outcome was seen to relate to all teachers.

> “If they do something wrong with their pupils, then the whole teaching profession, everyone is painted with the same brush” MC4

This was contrasted directly with other jobs where people could do a professional job but were not part of a profession. PTs accepted that this concept of carrying the weight of an entire profession was not the same, it was expected that different workers would do work of a different standard

> “Painters and decorators, perhaps, are not quite the same. Even though they do, obviously, you know, they do a professional job, but if they made a mistake, you'd probably think, oh yeah, that's fine” MC3

Although the conversations that the members of the group had in this area outlined these two distinct approaches, they did not make explicit links in their discussion that this was a facet that was a part of being a member of a profession, or something that could be used to describe and define it.

At the close of each focus group I brought people back to their definitions of professionalism. I wanted to know whether participants changed their minds compared to their earlier answers or whether they now agreed a common definition of professionalism. Participants gave longer answers than they had at

the start of the evening and recognised that their early responses had been very practical and easy to measure. Their closing responses sought to pull together some of the topics and themes that they had discussed throughout the evening.

> "It's definitely more than just adhering to certain standards, and things…it's about the knowledge that you've got, it's about how you act, it's about having networks like this, to be able to learn from each other about different aspects. And all of us being one profession" CT5

This recognition of being part of a wider network brought a sense of pride to participants and of their place in practice with one participant closing the evening by saying that she was going to introduce herself as a PT from now on, rather than as being from pharmacy (L4). These concepts of professionalism, attitudes and a sense of identity are explored further in my discussion.

As a result of regulation, participants described themselves as members of a profession and they recognised that this brought them a sense of identity and prestige. They talked about playing a particular part in improving care; they were meeting the health and social care needs of their local populations and working as a member of the wider health care team. They knew that they were providing a service to their local communities. They had shared identity, commitment and loyalties.

In their early responses to conversations focused on what professionalism was participants used different approaches and phrases to define professionalism from their perspective, but the common story to all of these was a link between professionalism and high standards. The word professionalism was associated with high quality, doing things in the right way and being recognised as an expert within a specific area of practice. The group recognised that it was a difficult concept to try to describe briefly and neatly and tended to concur with earlier responses whilst adding in their own nuances.

During the conversation participants covered a range of topics related to learning to join a profession both through formal and informal routes and the approaches that they took to maintaining their competence to practice through engaging with ongoing learning. They talked about finding their place within the hierarchy of pharmacy practice and more widely within the NHS healthcare workforce across a community. Each of these conversations highlighted a

different conceptual understanding of professional practice and their perspectives on working as professionals within health care.

Conversations related to regulation demonstrated that PTs found that there was a need to justify their roles and their status as a profession. They described situations where other health care professionals, outside of the direct community pharmacy environment, recognised and valued their input and expertise although this status was not seen as something which was recognised by the public and wider society.

At the close of the focus groups, the conversation returned to definitions of professionalism and a deeper and rounder response was shared by participants. They built on the earlier concepts of high quality and high standards and added in issues related to personal responsibility and behaving in a different way to non-professionals. This shift in definitions was accompanied by a developing sense of recognition of a personal professional identity – perhaps most neatly captured in one focus group by a participant who said that from then on she would introduce herself as a PT. This was greeted by other participants with a clear sense of pride.

5.3 Summary and next steps

This section has explored the key themes and issues shared by participants in my focus groups which offered common stories and perceptions across the four different sites. I followed an interpretative approach to surface those themes which highlighted the lives and experiences of the PTs, offered insight to my research questions and which surprised or challenged my own perceptions and ways of thinking. These themes were then taken forwards to the interviews which offered an opportunity for me to discuss these with the PTs again. This both sought to gain a richer insight to the reality of these themes for PTs and to reduce researcher bias.

5.4 Interview participants

Eight PTs from the focus groups volunteered to participate in the interviews, with two engaging from each of the focus group sites. In order to enable

continuity of comment from the focus groups, the same anonymised abbreviations are used consistently throughout. Thus London participants in the interviews were L2 and L3.

This section introduces each participant and expands the information given at the start of the chapter (5.1) about the route that they followed in order to become a PT.

The first topic in each interview was a reflection on the focus group and whether they had talked about it with colleagues afterwards. This sought to re-engage the PT with the focus group, their thinking and any impact it had on their practice. Some PTs described this impact in some detail and so I close each of these introductory narratives with a summary of whether they spoke with any of their colleagues or teams after the focus groups and what had changed for the individual since the focus group.

5.4.1 L3

L3 was a female who had been registered with the GPhC for less than a year but had worked in pharmacy practice for almost ten years. She initially worked in a pharmacy in Ireland and had then qualified as PT through a college course. When she moved to England it had taken over a year for her qualification to be recognised by the GPhC; during this time she had worked as a medicines counter assistant in community pharmacy. She explained that she found this to be frustrating and demoralising. As soon as her qualification was recognised and she was able to register, she applied for and gained a PT role working in a community pharmacy within a large London NHS trust. This enabled her to work as part of a team and gain experience in both community pharmacy practice and a secondary care setting. She saw this overlap as one of the great parts of the job and working environment. She explained that there had been no mention when she was at school of the job of the PT and that when she told people that she was studying to become one, she was often asked why she didn't become a pharmacist and finish the qualification. Even within the role she commented that she felt other people didn't really know or understand what she did. She talked about doctors and nurses who knew that she 'worked in pharmacy' but did not know exactly what was involved.

Although she had worked in a community pharmacy within the trust, she said that she felt that she was part of the wider hospital pharmacy network and that there were frequent opportunities to work and socialise with the hospital pharmacy team. She talked about the pleasure that she gained from supporting the development of other PTs and pharmacy team members within the community pharmacy setting. During the interview L3 explained that she had now moved to Scotland and had started to train as a nurse. She talked about the conflict that she had felt in making this decision. She felt that there were many opportunities for development and role progression as a PT but explained that she had started the process of applying to study as a nurse when her GPhC registration was taking so long. She had decided to continue with that course of study since she was moving to Scotland with her partner, but recognised similarities in the professional requirements of the two roles. L3 was the most engaged of those who spoke with me and followed up the interview with an email to share the additional reflections on professionalism that she had since we spoke.

5.4.2 L2

L2 was an Indian male who had initially studied and registered as a pharmacist overseas in India. He moved to the UK and found that his qualification was not recognised as equivalent to the pharmacy degree in the UK and so he had taken on a role as a PT because he was able to register as a PT with his Indian pharmacy degree. He had been a PT for around six years but had worked in pharmacy for over 15 years. Although he was eligible to undertake a conversion course to become a pharmacist in the UK he had made the decision not to do so. He explained that this was initially owing to the cost of the course but then, as he worked as a PT in England, he felt that he had more opportunities available to him as a PT than he would as a pharmacist.

“I personally love it, the PT-wise roles because I am able to do so many different things. When it comes to the pharmacist, from my experience point of view, they are limited to particular fields when they come, very hard to move from one.”

He spoke about pharmacist friends from India who had undertaken the conversion course and that, from his perspective, this was limiting their options

for future work. He described them as being blinkered as pharmacists. For him being a pharmacist meant following a single career pathway, being a PT offered a range of options. When L2 talked about his experience as a PT he described work across different sectors of practice. He had worked in hospital pharmacy and had been funded to undertake a number of developmental courses: he described his manager at the NHS trust saying that L2 had now completed all of the available learning to him. Following this he had started to work as a locum PT and had worked in hospital pharmacy, primary care, community pharmacy and prison pharmacy roles.

Since the focus group he had applied for a role with the IT and data management team at a local hospital and had recently started within that role. He explained that this used some of his skills as a PT in terms of understanding health data and the need for an attention to detail. L2 repeated that he would never have considered this type of role or opportunity if he had stayed as a pharmacist. L2 expressed concerns about the future of the PT role, explaining that the move to centralised dispensing was deskilling the PT and would limit the opportunities that he had enjoyed. This was why he had taken the IT role which he saw as a way to broaden his skills.

5.4.3 CT5

CT5 was a female who had made an active decision to work in a pharmacy because she had seen pharmacy teams working in different environments when she was at school. She remembered thinking that pharmacies looked clean and modern. She did not know exactly what the different roles were and did not see it as a choice to become a PT; she just wanted to work in a pharmacy. She had worked in pharmacy for over 15 years and registered as a PT in 2011. The first job that she saw advertised to work in pharmacy was a job as a delivery driver. She applied for, and gained, this role with a pharmacy multiple in order to gain a foot in the door and then took opportunities as they arose to gain employment in the pharmacy itself as a medicines counter assistant. After starting to work in the pharmacy she had learned about the role of the PT and explained that she worked hard so that she could get the opportunity to train and qualify as a PT.

Since the focus group she had been working in a primary care role offering advice on prescribing to practices in line with local CCG guidelines. She still

worked occasionally in community pharmacy because she wanted to keep her hand in and did not want to lose patient contact, which she said that she really enjoyed.

5.4.4 CT6

CT6 was a female who started with a Saturday job in a pharmacy around 20 years ago whilst she was at school, working on the medicines counter. She enjoyed the job there and contemplated working in pharmacy. However, her older sister went to university to study pharmacy and was very home sick during her time away. As a result of fearing that she also would have this home sickness, CT6 decided that she was not going to university. When she left school she worked in a bank and then at the council before she returned to work in pharmacy because she had enjoyed herself there and liked helping people and being involved in healthcare. It was after she started working in the pharmacy that she learned she could train to become a PT without going to university. She had not realised that this was the case and so had not considered this as an option. She qualified as a PT around 15 years ago and went to work in the pharmaceutical industry for a few years. She enjoyed the stimulation and teamwork of this role but found that she had reached the highest level open to her when she was not able to become a Qualified Person (QP). In the pharmaceutical industry a QP is a formal position which describes someone who is able to work at the highest level, sign off batches of medicines for distribution and sale and recognised as capable of taking responsibility for all stages of the manufacturing process. This left her feeling demoralised and so she returned to work in community pharmacy practice again. She gained her qualification as an accredited checking PT and found the job satisfying and personally rewarding.

Since the focus group she had been on maternity leave and had not engaged with other PTs during this time. She had lost her status as an ACPT because of a time limit on undertaking annual accreditation. She had not been able to complete the required reaccreditation exercise within a 12-month period owing to a period of ill health prior to going on maternity leave. Her plan was to take a new role with the CCG and not to seek reaccreditation. She explained that this was due to feeling disillusioned with the process.

5.4.5 MC4

MC4 was a female aged 55 to 60. She explained that when she left school (in the 19xxs) there were only two types of job available in the area. She had a choice of working in retail or the car industry. Her parents told her that industry was not an appropriate working environment for women, so she went to work in retail. The store she worked in was taken over by a national pharmacy chain and changes within the structure meant that her job was no longer available so she was moved to work on the pharmacy counter. She enjoyed the work and developed her learning and skills, becoming a dispenser and later a PT in 2006. She registered in 2011. She had remained at the same pharmacy since then and was well known by customers and local health care professionals in this position. Within her pharmacy practice she was often the single consistent professional staff member as different pharmacist locums came each day to deliver pharmaceutical services.

Since the focus group she had engaged the rest of the pharmacy support team in conversations about professionalism and why this mattered for pharmacy practice. She had spoken with them about treating people equally and with respect using their work with drug addiction clients as a focus. She talked about how she asked the counter staff to think about how they spoke with those accessing medication for addictions and the importance of treating them with respect. She had also started to reflect explicitly on the way that she worked and learned and contrasted this with some of the pharmacists that she worked with. She talked about one pharmacist who she recognised was clinically excellent, but who tended to be abrupt and rude with patients. She used this as an example of how being professional was not just about being intelligent but about people skills as well. The other big change for her since the focus group was a change in area manager, which could mean that she left her role in pharmacy. As well as working in pharmacy, she cared for her grandson. The new pharmacist area manager was trying to change her working hours, which would make it impossible to care for her grandson. The only outcome that she could see was to hand her notice in.

5.4.6 MC5

MC5 was a female who had worked as a Saturday girl in a pharmacy and had enjoyed it. When she left school, she applied for a full-time job and continued to work and develop herself in the pharmacy. She had not considered that working in pharmacy was a long-term career option and so she had contemplated becoming a teacher and applied to undertake a qualification in education. However, her pharmacist line manager encouraged her to undertake the PT development programme instead around 10 years ago. She registered in 2011. She had enjoyed the science element of the course but did not think that it linked to the work that she did in practice. She felt respected for her hard work in the pharmacy and recognised that she was a key part of the team.

Since the focus group she had gained a role in the hospital pharmacy team where she was working as the PT education specialist and guiding PT students through their NVQ programme. She was enjoying the role and said that it brought together her knowledge and experience of being a PT with her desire to do something in teaching. Although she said that she had not chatted with any of them about the focus group, she did think that professionalism was something she tried to teach her students by asking them to think about how patients saw them when they were working.

5.4.7 MT3

MT1 was a female who described herself as a child of the Maggie Thatcher years. She had left school with basic A levels at a time when there were over 3 million unemployed. She described applying for over 40 jobs and seeing an advert for a role as a PT in the local town newspaper. She applied for it even though she did not know what it was and felt that she was lucky to have got it. She studied to be a PT around 35 years ago in the hospital pharmacy manufacturing department and enjoyed the job. She felt that the course trained her well for this technical role. After many years working in the hospital sector she had applied for a job in primary care as it offered both promotion and career progression. She said that high level roles were rare for PTs. She felt that at that time in pharmacy, PTs did not move on, did not travel to a different place to work, they just stayed working locally to where they lived. She implied that this had now changed. Although there was high competition for the job she was

successful. She said that her Mum started to tell their friends that she got the job ahead of everyone else in England. Her pride in gaining the role was clear. She worked in a small team covering community and primary care and saw pharmacists as trusted colleagues who helped her to learn and develop.

Since the focus group she had only spoken with a couple of people about the topic of conversation but had reflected on her own behaviours a little and how these showed that she was professional. She felt strongly that professional practice was about following the right processes and working within your own competences.

5.4.8 MT2

MT2 was a female who described her working life as having two parts; before and after having children. Before starting her family, she had worked in the police force. When her children were growing up she decided to look for a role which was near to home and where it was possible to gain part time work so that she could be there for her children. She found a part time job in a pharmacy working on the medicines counter around 15 years ago. She enjoyed the job and found that it was a good fit for her. Even though her children had all now grown up, she continued to work in the pharmacy. Her career had developed and she had trained as a PT ready to register in 2011. She described her role as being a store manager. Although pharmacists were in charge, her experience was that of pharmacists changing regularly, different pharmacists were responsible for the practice each day.

Since the focus group she had spoken with various members of her team and asked them what they thought professionalism was. She said none of them could really explain it either. The pharmacy chain that she worked for had started to plan for contractual changes and a new dispensing model, called the hub and spoke model. This model would result in all routine prescriptions being dispensed in a single central hub. They would then be distributed out to local branches where the customer would collect them and receive professional services. This had resulted in her and one of her colleagues travelling between branches to introduce the new system. She felt that this had resulted in her feeling part of a different and much bigger team within the company, but also had raised her concern over change and the impact that this could have on the

various staff that she had worked with and managed. She also felt that this work across the company had given her a role in assurance of standards across the different sites.

5.4.9 Reflections on participants

From these different vignettes, the diversity - in terms of age, experience and nationality – amongst PTs in this study can be seen. The majority were female, which reflected the register of PTs (GPhC, 2019, p.251). No common route into the profession was reported, a finding that aligned with very little being known about the role of the PT until people started to work in the pharmacy itself. This latter finding partly explained why PTs rarely make a conscious decision to take on the role.

I started each interview with a structured conversation around how each of them had become a PT to learn more about the route each had taken into the profession. Each of these eight vignettes demonstrated that the PTs did not see themselves as having chosen to become PTs initially. They had gone to work in pharmacy and then learned about the role of the PT. However, they found that becoming a PT was something which was both developmental and aspirational once they had learned that the role existed and what it offered to them. It was developmental because it was a step up in practice and becoming something different and better than the role that they previously held within the pharmacy practice. It was aspirational because it brought with it status and responsibility and, in applying for the role and taking on a proscribed programme of study, they were proud that they were moving to a more professional position.

The pace of role change experienced by the eight participants who elected to be interviewed was striking, with half describing new jobs and positions, including changes of sectors of practice, in the period between the focus group and interviews. This role change was not routinely to remain within pharmacy however. L3 was training to be a nurse, L2 had moved to an IT role. CT5 and MC5 had both remained in pharmacy services, but had moved to a different sector. This change in career enabled the conversations to explore behaviours and reflections about the professionalism of the individual which were broader than a single role. The discussions could unpick opinions around consistent attitudes and approaches which were linked to professionalism.

5.5 Reflections on the interviews

The themes which arose from the interviews related directly to the schedule and covered the essential attributes of being a PT; those activities and attitudes that they saw as showing that they were a professional. I have summarised these as attributes of a professional. As I interrogated the data from the interviews to explore what they considered to have been the markers of this enhanced professionalism in their role as a PT, there were two key areas that stood out. One was engagement with learning and the other a focus on patient care.

5.5.1 Attributes of a professional

The first broad area of the interviews considered the attributes that PTs associated with working as a professional. These related to elements of high-status roles and obligations on them as individuals.

5.5.1.1 Management

Of those working in community pharmacy settings, all of the PTs talked about their roles as managers within the pharmacy. Although there was no available data on the number of pharmacies which were being run by a locum pharmacist at any time, most pharmacies will be led by a locum from time to time. For those practices which are owned by a single pharmacist, a locum is required to cover their days off and annual leave. For pharmacies owned by national companies, locum cover was typically needed to enable the pharmacist to have time off and to enable the practice to be open whilst pharmacists were being recruited. As the PTs explained, during these periods of time the PT was the point of constancy and stability. It was not clear whether their role as a manager was recognised by their employer, but their responsibility for the practice was evident.

> “They aren't working how we like them to work. Because don't forget, we're there every day, and they're coming in for a quick shift” MT2

The PTs explained that regular customers recognised that the pharmacist differed on a regular basis, so would actively seek them out for questions and to

verify issues relating to their routine care or for general questions about stock and sales. The PT would also take responsibility for managing staff rotas, organising lunch and other breaks and making sure that stock was being ordered and put away appropriately. Where the branch was covered by locum pharmacists for an extended period of time, the PT also described their responsibility for assuring that staff were being trained and supported appropriately.

> “We actually do become more like the managers, even when it’s training, because when you’ve got a new locum there you’ve got a new person” MC4

The PTs talked about the challenges associated with this, particularly since the pharmacist was legally and ethically in charge of the practice. These conversations looked at the responsibility that the PT felt for the service from all members of the team.

Some PTs talked about the approaches that they used if they felt the pharmacist was being unprofessional, for example MC1 talked about a pharmacist constantly swearing. Since she reported to the pharmacist, she needed to find strategies to manage upwards and influence behaviours. She explained that the approach she had taken was to link the behaviours to age and respect; she asked the pharmacist whether she would talk to her mum like that and tried to imply that since she would not swear in front of her mum, she shouldn’t swear in the pharmacy either. She had not been direct or explicit about it and it had not worked. She explained that she had less respect for the pharmacist as a result of this behaviour, despite the pharmacist being excellent clinically.

PTs talked about their role in leading the work of the wider team, for example in offering contraceptive services to teenagers and ongoing support for substance misuse clients. They described ways in which they had made explicit links between professionalism and behaviours as an outcome of the focus groups. They linked a need to treat all clients with respect to services for substance misuse, and a need to keep things confidential with respect to providing contraceptive advice services and supplies of free condoms.

A constant focus was on the need to assure patient care through effective service delivery. PTs recognised that as the point of stability in the pharmacy team, they took responsibility for following through effective systems within the pharmacy. One PT explained that each day began by guiding a locum pharmacist through the standard operating procedures for the practice and checking that no changes or alterations would be required.

PTs also explained how their freedom to leave the pharmacy whilst it was open resulted in them taking the lead for relationships with other local health care providers. The PTs described how they visited local practices each day to collect prescriptions, check for any questions or issues and maintain positive dialogue with practice staff and receptionists. Although this was under the direction of the pharmacist, they were aware that it was their behaviours which had a direct impact on how the pharmacy team was seen and represented.

5.5.1.2 Confidentiality

There were frequent references to the obligations that PTs had to maintain the confidentiality and privacy of patient specific information and details. Some of the comments related to the environment itself and some to the personal values of the PT to keep information private. PTs explained how they assured confidentiality through finding private spaces for conversations in the pharmacy so that they would not be overheard. They explained that all of the screens in the practice were angled away from customers so that personal information was not visible. And they talked about making sure that anything with someone's name on it was stored in a separate part of the pharmacy so that it was not on public view. Knowing about each of these factors was described as the way that confidentiality was instilled in them.

This sense of it being instilled came through strongly when PTs were asked about issues outside of the work place – for example if they left the pharmacy and got a new job, could they then talk about what they knew about patients.

> "Yes and I think it's also about the character of the person, you know, some people might say, well I'm not there anymore, so it doesn't matter, but it is, you are being professional towards your customers and your

> patients and wouldn't even enter my head that you would talk about somebody else, even if you weren't doing the job and that is…it is about…that is definitely being professional, because I don't think you become less professional because you're not in that job at all, you know." CT5

This inability to contemplate talking about patients was common to all PTs, with one PT (MT2) taking it further in explaining about living in the same village as many of her customers. She said that outside of work she had to forget what she knew about them, their therapy and their conditions.

5.5.1.3 Appearance

Half of the PTs talked about appearance not being a marker of professionalism or professional practice but followed these comments up with assurance that they dressed in a smart, appropriate or professional manner.

> "I try and dress…it's not about dress but I try and dress in a way that I feel that I can then portray professional person." MC4

There were discussions around the need for their appearance to be in line with what customers would expect to make sure that there was a level of trust in them and what they had to say.

5.5.1.4 The distinctive nature of pharmacy practice

All participants emphasised that working in a pharmacy was different. Although the pharmacy was situated on the high street, it was not simply a shop like other local businesses because it was also part of the NHS. However, unlike other environments where health services were accessed, it was not purely a clinic and appointments were not required. This meant that those working in the pharmacy needed to recognise the different needs of the people using their services and behave appropriately.

> “People don’t come to the pharmacy for something like a box of chocolates, they come because they have to, for treatment for a condition that they wished they didn’t have. The pharmacy team need to respond to that and engage with them appropriately. They don’t want to be there.” MC4

This concept of being distinctive was linked directly with professionalism by CT6:

> “You can’t just go and do a job then leave and forget about it. Like you are always that registered profession.” CT6

This recognition that the pharmacy was different to and better than other shops on a high street was what had drawn many of the PTs to apply to work in pharmacy, even though they had not known about the PT role. There were links between this distinctive nature of the pharmacy and the range of people who came to access pharmacy services. Drug users were used by some of the PTs to explain how their services were needed for everyone, and how all customers had to be treated in the same way.

Even when describing pharmacies which were within wider stores, the PTs found examples of how their work was distinct to other activities within that store. The PTs talked about the staff on makeup counters being free to gossip and chat, but in the dispensary, the team were always focused on appropriate behaviours.

5.5.1.5 Engagement with learning

The final key theme I identified related to each individual constantly trying to improve their knowledge and their practice. This was described as encompassing everything that the PT did; as with the focus groups, learning was just seen as an essential part of the job.

Routine learning to do the job

There was an awareness of the large evidence base that PTs needed to be able to access and navigate in order to get things right and the need to think about the processes that they followed as they learned.

> "I don't know because you couldn't do the job without it really. You really need to be…I mean whenever I'm working in a practice, doing anything I've got, I've got hundreds of tabs up for all our guidelines, different guidelines we've got, just so that I can double check everything I do, really and there's stuff in people's records that you don't understand so you're googling it and you need to be able to do that because if I phoned up the office and said can you help me with this, they'd ask me those questions anyway. So, I've already got the answers for them." MT3

PTs talked about studying in the evenings and out of hours to learn about therapies that they had encountered during the day. This was not considered to be a burden but something that was part and parcel of being a PT.

> "Sometimes you can work through things yourself, it's just, you can't do the job without it. So, I don't think it's anything to do with professionalism really. Well yes, it is because you need to maintain a certain level of education and understanding but I couldn't do the job if I didn't. You have to keep yourself up to date." MC4

In the interviews PTs discussed attending training programmes that they needed to work as a professional, discussing what they saw as higher-level skills. They discussed learning programmes that taught them how to listen more effectively and explained that this was essential for being able to answer questions from doctors and patients alike. PTs recognised that people came to them with questions and that they needed to make sure that they understood the question being asked of them and what action they needed to take as a result. They recognised the potential consequences of getting something wrong in respect of patient safety and their duty to get it right.

> "Make sure I'm listening carefully to the query and understanding what needs to be done as a result of it and what I need to do as part of that and make sure that I actually do it and do it well. Do it to the best of my ability." MT3

There was also a recognition that people probably were not aware of the additional learning and ongoing development that PTs engaged with in order to make sure that they were competent in their practice. They knew that it

mattered to patient care and so it mattered to them. It was part of their professionalism.

> “Even when the patients can’t see you directly and don’t know you’re there, you’re still making sure that you give that highest quality service because you know it matters.” CT6

Throughout the comments that PTs shared about routine learning the expressions used made direct links between the need to keep learning and doing things to the best of their ability. Although this was not stated explicitly by PTs, there was a clear sense that the only way that they could do their best was to keep learning and to keep improving.

Striving to improve

Since there were links between ongoing learning and continual improvement, the perceptions from PTs on why they needed to keep improving are of relevance. PTs talked about the importance of the dispensing process, they were the last safety check between the prescriber and the person taking the medicine. Dispensing is a core task for the PT and they discussed the approaches that they took to make sure that they got this right and that patients received the right medicines, dose and accurate treatment. Their role was in the accurate provision of medicines.

> “And then you need to complete that task [dispensing], go back to what you were doing, but start afresh, look at it with fresh eyes rather than, oh, where was I up to? So it’s making sure that things are done correctly and accurate.” CT5

Although PTs recognised that their prime role was in the accurate dispensing of medicines, they talked about the behaviours that they needed to demonstrate whilst they were doing this. And they linked this to their behaviours as they were working through different aspects of their roles. They knew that being professional was not just about getting it right, but about the way in which they worked to get it right. One PT in particular talked about this in direct relation to attending the focus group. She explained that she was now actively reflecting on her behaviours at work and how this supported her position as a professional and how others viewed her.

> “I think about it more, whereas before I think before it just came through from the top, you do try and emulate good examples and good behaviours, but I actually think about it now and when I get difficult queries, things that I need to do, I actually think how I need to make sure that I’m seen to be professional when I answer it.” MT2

This clear recognition of being responsible for their own behaviours and how this impacted on the way the whole team was viewed was described by all of the PTs in the interviews. It can be seen that PTs knew that their role was to assure patient safety within a changing environment and the only way that they could do this was by constantly learning.

CPD

The need to engage in learning remained a constant theme across all eight of the PTs, but there was separation between the learning that they did in order to be good at their jobs and offer high levels of patient care, and the learning that they needed to record as CPD to remain on the GPhC register. These were talked about as being separate things and the PTs did not link the two.

PTs did not link ongoing learning with CPD, which was described as a required system for revalidation. When it was mentioned explicitly, CPD was discussed only as a process to be followed to remain on the register. It was not linked to patient care or ongoing self-development.

> “Like I do CPD to do my job and I record it because I need to keep my job and that’s it but yes I only do the recording because I have to.” MT3

It was recognised as a job that needed to be done, but not one that was easy or directly linked to improving services.

> “I could be a lot better doing my CPDs but I haven’t found anyone yet that is.” MC4

This separation between the routine learning which was part and parcel of the role and the recorded learning that was needed to retain registration echoed the conversations of the focus groups. When discussing this in the interviews, PTs still talked about ongoing learning and CPD as two separate areas of practice and did not recognise that this was how they discussed it.

This separation between ongoing learning and CPD was not highlighted to PTs during the interviews and they were not invited to comment on it.

5.5.2 Focus on patient care

The overriding sense of caring for people, whether these were pharmacy customers or people who were accessing health services, was implicit in the conversations that all of the PTs had. It was seen as something that was part of what made pharmacy a distinctive presence on the high street.

For the PTs, being a professional meant that caring was not just a 9 to 5 working hour's role, but something that really mattered and helped to define who they were and how they earned the right to call themselves professionals. It was encapsulated as being who they were, not what they did. This showed that PTs recognised that it was part of their identity, even though they did not name it as such.

> "Well you have a lot more responsibility. I mean you have responsibility doing a job anyway, but because you're a registered profession, you can't necessarily leave it at work. You know, you can't just go and do a job then leave and forget about it. Like you're always that registered profession. Does that make sense?" CT6

PTs talked about patient care as something that was routine and the reason for their roles, but their conversations about professional attitudes linked to this considered a more enduring element to the care. Conversations considered the difference between doing a job and being a professional and sought to tease this out by thinking of going the extra mile because people needed it, not because it was funded or would bring a financial benefit.

> "I think doing a job is just turning up doing what has to be done and then going home, but if you're professional, then you just go above and beyond." MC5

Repeatedly PTs talked about caring for people as just a part of what you had to do when you worked in pharmacy, and what made people choose to work in pharmacy. It was recognised as being associated with pharmacy practice and so was therefore automatically what was associated with the role of a PT.

5.6 Summary

This chapter shared the findings from my engagement with PTs in focus groups and interviews, offering both a description of the key themes identified and my interpretation of these comments and perceptions.

The common themes across focus groups identified a lack of intention in choosing to become a PT which was followed up in the interviews as an unexpected finding. PTs demonstrated a consistent recognition of the responsibility of their role and a need to meet the expectations of people using their services in the pharmacy.

In the next chapter I draw these threads together to propose a narrative of the process by which PTs become professionals.

Chapter 6 Becoming a professional, a sense of hard work and journey

This chapter pulls together the findings, interpretation and analysis and considers their meaning in relation to the PT workforce. It refers back to the literature review and the questions that were raised within it, adopting the same structural framework to consider how professionalism is taught, learned and assimilated in specific relation to PTs. This provides a narrative for the development of PTs as professionals.

6.1 Introduction

I undertook a qualitative study to start an exploration into professionalism for PTs. The questions that I sought to answer were:

> What do community PTs in England understand by the concept of professionalism in the context of their working lives?
>
> Is that perception affected by their generation of practice in relation to the onset of regulation?
>
> Do PTs perceive a link between CPD and their professional status or practice?
>
> How do community PTs meet the CPD requirements of their professional status?
>
> What barriers, and what affordances, do they encounter in meeting these requirements?
>
> What are the implications of these findings for ongoing learning for community PTs?

These questions were informed by the literature review and explored through a series of focus groups and one to one interviews which engaged PTs in sharing their own perspectives and stories to offer richness to the study.

I used an interpretative approach to draw these explorations together and consider what the implications of this work were for a greater understanding of how PTs were becoming professionals.

For the literature review I explored the wider research evidence base to focus on the following questions:

What is professionalism

How is it learned, taught and assimilated

I revisit these questions with a specific focus on the implications for PTs to provide a structure for my discussion as this highlights what this study has added to the knowledge base within this topic area.

6.2 What is professionalism for a Pharmacy Technician

This first section explores professionalism from the perspective of the PT. In common with other research, this study did not find a clear, common definition for professionalism or what it meant to be a professional. For example, in their review of published literature relating to professionalism, Van De Camp and colleagues found 57 attributes of a professional (Van De Camp et al., 2004) were described through their search which they summarised to three domains: interpersonal, intrapersonal and public professionalism. They did not attempt to rank the attributes nor to define how many were needed to be able to consider oneself a professional. Taking a prioritisation approach in his exploration of professionalism within medicine, Hilton (Hilton and Slotnick, 2005) proposed six personal attributes which a professional must develop. He suggested that it is essential that the individual develops a high level of ethics and that they must engage in a social contract. These elements were reflected in this study.

The PTs who participated in this study provided an enduring and authentic shared narrative of their experiences and of their perspectives of professional practice. For PTs, professionalism is linked with high levels of service, an altruistic care for customers and taking personal responsibility. As this is a first of its kind study into PTs and professionalism, each of these areas is new knowledge about this group and their development of professional practice.

6.2.1 Shaping a concept of professionalism

In the focus groups and interviews PTs explored broad understandings of professionalism. They had started to identify areas of their practice which made them different from those in other jobs, even though they themselves did not articulate these issues as being part of their professionalism. This difficulty was not just in defining professionalism, a theme which was common across the literature explored in the review that forms the foundation for thesis. The difficulty that participants found was to explain how they knew that they were engaging in professional practice and the contrast between their regulated position (where professionalism had been thrust upon them) and the roles that they had been undertaking for a period of time that extended beyond this.

There was a clear message that high levels of service were needed so that people using pharmacy services knew that they could trust in the pharmacy and the advice or medicines that they gained from them. Through all of the focus groups and interviews, PTs described how they had developed professional attributes, how they knew that they demonstrated them in their routine practice and why these were essential for a position of trust. These come together in the descriptions that PTs gave of high levels of service.

The challenge of trying to articulate the difference between being a professional and acting in a professional way was surfaced during conversations about offering high levels of customer service. Participants recognised that people working in many other roles also have a sense of pride in their work and promote excellence in customer service. They talked about decorators who take pride in the finished outcome and refuse collectors who return the bins to people's homes carefully. These activities were described as acting professionally, using the term to describe high standards and the sense of pride that an individual has in doing a job well.

Although the PTs struggled to claim that high levels of services were a marker of their professionalism, the persistence of this message through the different sessions and interviews demonstrates that this concept and ethos was highly developed in the PT groups. This is in line with Hilton (2005) who accepted that these attributes of service are present in all occupations but must be more highly developed within a profession. The considerations of refuse collectors

being professional if they returned the bins neatly after collection offered additional insight to this concept. The group agreed that taking the extra time to return the bin, to demonstrate care for the customer, was a marker of high service and evidence that the bin man was doing a professional job. However, this was not an expectation of the role and was not something that was uniformly experienced. PTs recognised that service levels were highly developed for them and that this was an expectation of their position.

PTs talked about customer service as not only about doing the right thing for a customer but also knowing why it was important to do this. They recognised a sense of difference to their roles which made customer service essential rather than a nice to have. This orientation of customer service meets with the ten characteristics of a professional which underpinned the work of Beardsley and Benner (2000), shown below in figure 4. The orientation aspect of this is the underlying ethos that PTs wanted to offer high levels of service, it was not something that they were made to do, but something that they chose to do.

Figure 4. Attributes of professional practice (adapted from Beardsley and Benner (2000))

Service orientation	Unique knowledge and skills	Pride in the profession
Conventional relationship with clients	Commitment to self-improvement	Accountability for work
Ethically sound decision making	Creativity and innovation	Leadership
Conscience and trustworthiness		

A further common theme in the perceptions that were shared for this research was one of professional practice that arises through focusing on a sense of altruism; the PT's responsibility was to the patient and not to themselves. This aligns with the work of Klein (2003) who explored development of professionalism for medical residents.

The sense of altruism was central to the work and practice of the PT and was described as a need to work to improve patient care. Again this was not claimed explicitly but surfaced in my analysis of the transcripts of the focus groups and interviews. PTs talked about other jobs which people could just walk away from

at the end of the day, but that they knew that their jobs were different to this. This difference was both a sense of the identity of a PT and also an obligation of the role. Comments were made about suddenly remembering things on their days off and calling in to the practice to make sure that it was being handled appropriately, and in staying behind for extra time to make sure that a patient had the medication that they needed when they needed it. Indeed, one of my participants was late arriving at the focus group because there had been a tram crash in a nearby city. She knew this would put her team under an increased burden and so had gone to work even though it was her day off. And having worked a full shift, she then made the journey to join my focus group because she had signed up to it and wanted to represent her profession.

It is relevant that these were general comments made by participants rather than points that they were actively trying to promote. This demonstrated the routine nature of these issues and that it was simply recognised as part of what they did in practice.

Altruism and putting the needs of patients ahead of one's own is recognised as an essential element of professional practice (Ratanawongsa et al., 2006). This was something that each of the cohorts recognised as part of their role and again forms evidence that the PTs are acting as a group of professionals.

Appropriate language and communication were stressed as essential by participants, particularly in relation to putting the person at the centre of their care. This involved both showing respect to the individual, regardless of perceptions of their status, and also taking direction from the patient on the level of language that should be used during their communication. Participants agreed, for example, that they would only use first names for their customers when given permission to do so. They recognised that the important outcome was for the individual to understand what was said to them so that they could play a part in the conversation related to their health, rather than the PT using their higher level of knowledge about medicines and conditions in order to show off their skill and ability. This use of knowledge for the betterment of others rather than as self-aggrandisement was seen as an important marker of good practice.

> “Putting your best voice on, and using the big words, and, you know, if you're talking to someone who doesn't understand that, that's no good to anyone, is it…to be professional you talk to them on their level.” CT2

Although it was a subtopic to the main focus on person centred communication, PTs also discussed use of professional language and the need to find the balance between being approachable and over familiar. The cohort agreed that referring to patients as “babs” would be inappropriate but that it would be similarly wrong to be over formal or “stuffy”. However, this was considered to be a mark of appropriate manners rather than a sign of professionalism. This is in contrast to the work of Rutter (2010) with undergraduate pharmacy students who believed that courteous language was evidence of professionalism. The reasons for this were not explored in this study and may reflect differences in maturity rather than differing views of professionalism.

These different aspects of customer service, high quality and a focus on the needs of others have all been shown in other research to be attributes of professionals. They were all clearly demonstrated by the PTs in this study providing evidence of the professional nature of their work and practice. The inherent professionalism of this element of their practice is strengthened by the lack of significance these topics had for the PTs in the study. They discussed them because they were routine and standard practice, not because they needed to argue for recognition. Professionalism was normal.

6.2.2 Respect for self and others

Being a professional means having to make a sound decision for another person which may be in conflict with their stated desires.

Participants recognised that there were times when they needed to assert their position and explain to customers why it was not possible to meet their needs. In some cases this was reported as a direct learning experience. In the focus group, NC1 described observing a doctor managing expectations of a client and how she learned from this.

> “He was getting quite shirty with the doctor, and the doctor just said, now, so and so, I'm telling you and you will listen. And he was like, oh I'm really, really sorry doctor, and then he tried to tell me that we would deliver after eight o'clock on a night. And I said, no, we can't do that, you know we can't. So he started shouting at me, and I went, excuse me, there is no need to shout, and you know we don't deliver to you after so and so.” CT1

In other cases it was recognising that medicines could be dangerous and the role of the PT being to ensure the safety and well-being of the individual (see chapter 5 – focus groups). Here the PTs demonstrated their awareness of the limits that were present in meeting the needs of the customer. They recognised that they were responsible for ensuring the customer’s safety and wellbeing. For example, PTs talked about prescriptions which were not correct and the difficulty in accessing the prescriber for it to be amended. In one particular case for a methotrexate prescription, the PT was so concerned about the dose that she refused to make the supply to the patient. The prescriber phoned the following day in a panic having realised their error and explained that the PT had possibly saved the patient’s life.

Recognising and acting upon the tension of making a decision which is in conflict with another’s thinking is an example of the core of ethical practice, which Hilton (2005) claims differentiates a routine occupation from a profession.

This sense of care for the patient and for helping them to gain the best outcome ran through other topics as well. Some of the PTs talked about drug addicts, homeless people and others who are potentially treated as having less value within society. They made a point of explaining how they would treat them in the same way as every other customer, take the time to identify their needs and then meet their needs and provide medication with respect and a level of care.

The PTs were frequently the point of constancy within the pharmacy practice. The services of the pharmacist were being provided by a locum and the practice was being led and managed by the PT. One outcome from this was the customer wanting to talk to the PT about their particular issue. PTs recognised that this brought with it a need to be aware of the limitations of their role and competence and also that they could become party to privileged knowledge.

They had a duty of care to the patient to engage the pharmacist appropriately in resolving their health issues, and they had an ongoing obligation to treat the privileged knowledge that they gained with respect and maintain confidentiality.

As one PT explained, confidentiality is not just about keeping an issue secret wherever you may be, it is also about not allowing your knowledge to change the way that you engage with an individual if you encounter them outside of your practice. This was a lady who worked in a small village, so regularly encountered her customers at social events, church services etc. She recognised that she knew a range of things about them such as what illnesses they were living with, whether they had infections and whether they were pregnant. However, this was privileged information and not something which she had a public right to know. It was up to the individual to talk about that information in public, or to acknowledge that the PT knew it, before the PT could talk about it outside of the pharmacy setting.

In the interviews I probed further in this area to determine whether there was a sense that this was role specific or whether it would be lifelong. If a PT stops working in pharmacy and renounces their role and registration, would it then be appropriate for them to share what they had learned. This was a complex question to seek responses to, but it was apparent that my cohort felt strongly that they would never share what they knew about their customers and patients. It was something which had not occurred to them and felt alien to think about or consider – I had to rephrase the question in several ways to find an approach that they could answer. This was not due to communication difficulties, it signified how deeply they held the value of maintaining confidentiality. Breaking confidentiality was literally unthinkable to them.

6.3 Nature of professionalism

The concept of professionalism demonstrated by the PTs aligns closely with that of democratic professionalism (Sachs, 2001). Democratic professionalism is the ownership of the concepts and ethos of professional practice by the profession itself. The routine nature of service level, quality, altruism, customer focus and respect for all parties shows that these were what mattered to the PT. These elements drove professionalism for the group and determined their role, ethos and ways of working. It is key that this was very much their lived experience not something which had been forced on them. They talked with pleasure and pride about the way in which they went about their practice.

For the PT, professionalism is described by consistently high levels of service, altruism and customer care. Each of these attributes is offered by the PT because it is their responsibility and duty and is a part of their routine practice. Although it is an expectation of their role, PTs engage in these areas because it is intrinsic to their identity as a PT.

PTs had an implicit understanding of the privileged role that they were increasingly playing in health care and they treated this role with respect and a sense of pride. They knew that they could make a positive impact on the health of those using pharmacy services and they were committed to engaging appropriately and effectively with their customers to maximise this. They also knew that this role in turn brought an onus to treat everything that they learned and did with respect, and that this onus would be enduring even after they stopped work in pharmacy.

6.4 Pharmacy Technicians - how professionalism is learned, taught and assimilated

The framework of professional socialisation (Weidman et al., 2001) formed the structure that underpinned the focus group discussions. When Middleton (2008) used professional socialisation to explore PT professionalisation, she found no evidence that it was applicable at that time point for a developing profession. Twelve years later this remains the situation and professional socialisation does not have sufficient strength as a model that describes the development of the PT profession. Despite this, it offers a useful structure to guide the development of this section and to underpin future development and planning.

The three broad stages of professional socialisation are anticipatory, formal training and post qualification.

6.4.1 A lack of anticipatory socialisation

The theory of professional socialisation contends that people start their journey to join a profession by first building a sense of personal identity with that profession (Goslin, 1969). This was not the case for any of the PTs who participated in this research study. As they talked about how they became PTs, the common thread was one of necessity and serendipity rather than choice. This is in line with research by Deselle (2016) who commented on the serendipitous route by which PTs for his US study had taken up their positions.

For many members of the focus groups, the story was one of seeking work in a shop as it offered flexibility in working hours whilst they were raising a family or of referrals from a job centre as they needed somewhere to work. Older members explained that they had been looking for a job in a period when unemployment was high and they had limited formal qualifications; the change in social climate and availability of work was a factor in deciding to work in a pharmacy that I had failed to appreciate. The two participants who worked for a large supermarket pharmacy chain had both started by working in the supermarket. Having spent some time working on the pharmacy counter within the store they had been inspired and encouraged by the pharmacist manager to undertake the PT training course.

This latter experience of being inspired and encouraged was a common route through to starting the formal pathway of learning to become a PT. Serendipity and need were the drivers for working in a pharmacy, the recognition by an external agent (typically the pharmacist) was the catalyst for development into the professional role of the PT. In this way the pharmacist was highlighted as a positive agency for the development of the individual and recognition of their potential.

6.4.2 Impact of family

Professional status is conferred on an occupation because society believes that the role is one which deserves to be considered of the appropriate status (Larson, 1977). In the focus groups and interviews, I used the question about the reactions of family and friends to them becoming PTs to gain a sense of whether a sense of status was something which was present for this developing role. This also linked to the theory of professional socialisation, where the anticipatory stage is also influenced by the opinions and concepts of family and friends.

Although the PTs could share examples from their practice where patients and customers had conferred status on the PT, this was also closely linked to the working environment and a potential concept of status based on this clinical environment. Learning more about how family and friends responded to the individual becoming a PT offered an opportunity to explore how the role was perceived outside of the direct practice environment.

There was a clear sense of pride in the achievement of the individual to gain employment as a PT. This came from comments such as “you’ll have to keep yourself clean now”, and a mother explaining to her friends how important her daughter was for gaining a role as a PT.

The impact of family was seen more clearly in my Coastal town focus group where a mother attended with her son and, from the same pharmacy, twin sisters attended. It was clear that in this pharmacy the mother occupied a key position in the practice as the role model for the other PTs. Her son described how he had learned his craft from an early age by working alongside her in the pharmacy and although his role had now grown and was different to hers, he described her as the driver for his decision to be a PT. The sisters discussed

the leadership and management style of this matriarchal role model and tried to explain how it was the ethos of her work that helped them to attain their current role and level of service. They in turn had encouraged their younger sister to join the pharmacy team, because they could see that she was the ‘right type of person’ to work there.

A fifth participant at that focus group described her sister’s decision to study pharmacy as having been a strong factor in her choice to become a PT. For this PT, a move away from home was frightening and so she had chosen to be a PT as it meant that she could get the qualification and the job without leaving home. It was clear that she held her sister in very high regard and that becoming part of the pharmacy workforce was something that she took pride in.

Overall however, awareness of the role outside of the immediate setting of the pharmacy itself was low. Even CT participants described roles in pharmacy as “not something that you learned about at school”. PTs described a lack of knowledge and insight from friends related to the reality and seriousness of their role with comments such as “it’s just counting tablets” used to highlight this.

There was a sense of pride from family members in the nature of the work that they were doing, but they also reported indifference and lack of understanding from their friends. Neither knew the full range of services offered in a pharmacy, nor the level of responsibility that the PTs described themselves having.

The lack of awareness of the role at school level and as a future career prospect limits the opportunities for an individual to consider themself in relation to the PT position. There was no evidence of anticipatory socialisation amongst the groups. This has not prevented the PT from developing professionalism, nor from working as professionals. It may however be limiting the wider awareness and development of PTs as a profession and acting as a barrier to those who would be keen to join the profession if they knew about it.

For a group that has only been regulated as a profession since 2011, it is perhaps not surprising that there is not a high level of awareness in society of what the practitioners do and the level of responsibility that they take. My participants made it clear that their families had a sense of pride in the work that they did, that working in a pharmacy was seen as something special and that it

was a job worth doing. But this did not yet translate to the role being widely seen as worthy of being considered a profession.

Participants discussed a need for the profession to actively take steps to describe what it did and raise the profile of the role of the PT. They felt that if more people knew what they did, then more people would see this as a career choice and plan to move into this area of practice. The aspects which had attracted them into the role initially were still present; they recognised the flexibility that the role continued to offer, which was good for those wishing to start a family. They also saw that the role had grown and developed, particularly over recent years. Being a PT offered growth and development within the role, opportunities for career progression as a clinician in secondary care and as a manager in community pharmacy. It was a professional group that was open to those without academic qualifications at degree level who enjoyed a science based role, but the focus on patient care gave the role an intrinsic value and the practitioner a sense of self-worth.

In their 2014 report to the GPhC, Jee and Schafheutle (Jee, S. et al., 2014) found that PTs based in community pharmacy found it more difficult than those based in hospital pharmacy to clearly describe their role. Although that report was investigating the fitness for purpose of initial education and training, and so its focus was on exploring how to provide training for an ill- defined role, this finding is relevant to this research study. The role needs to be well defined and understood to enable the individual practitioner to start to build a professional identity.

The conversations and shared experiences of participants in this study showed that PTs describe their role in terms of the practical aspects, future opportunities and the underpinning ethos of professional practice. They work as professionals. This forms the foundation for new recruits to recognise that this is a professional group that they would like to join. It is this foundation which will enable the anticipatory socialisation of future learners who will then be attracted to the PT profession as they envisage themselves undertaking the role and being a member of that profession.

6.5 Formal training

Participants could not easily describe how they had learned to be professional. It was not something that they had been taught, or something which had been necessarily explicitly demonstrated to them during their working practice. Some of the group were able to describe ‘old school’ individuals who had guided them through an apprenticeship period which had included learning how to behave as well as what to do. These individuals had demonstrated specific actions and behaviours in their practice which the PTs in turn had tried to demonstrate in their own roles and in the training that they had then provided to others.

In their review of professional identity formation (PIF) in pharmacists, Noble (Noble et al., 2019) included 22 papers that considered this across the undergraduate curriculum. They recognised the challenges of PIF and the role of the mentor in starting to address this. One of the challenges described considers the specific expertise of the pharmacy student (knowing about medicines) in relation to engaging in patient care. The curriculum for pharmacists was often detached from patient care and looked at the use of medicines to manage diseases. To gain a professional identity the pharmacy student needed to relearn how their knowledge related to caring for patients.

This benefit of support from a mentor was described in recent literature relating to the pharmacist seeking to gain a new professional identity as roles in general practice were formed (Hazen et al., 2018). What is lacking is a formal structure or curriculum to ensure that this takes place for all PTs.

For PTs learning is largely undertaken within the workplace and so the direct practical application of their developing knowledge is easier to understand. However, this was not raised as a marker of professionalism by this cohort and was discussed with reference to the job that they did. Participants were clear and enthusiastic that it was a role which was needed and a job that was worth doing. They found it difficult to describe how their role was now a profession rather than just a job. As they discussed their work, they recognised that they were trusted by members of the public both for their knowledge and their awareness of when they needed to refer to another member of the health care team. They were also aware that they were valued and trusted by other health care professionals, both within the pharmacy and in the wider care setting.

There was a clear sense of trust and recognition for their role, which they could provide evidence for from other people's comments, but which they did not consistently acknowledge as being something that they deserved or owned.

There are different theories of how people learn. Sfard (1998) described two metaphors of learning as acquisition and participation and outlined that both needed to be considered relevant to practice. For PTs the acquisition approach is seen in the formal qualification which must be gained in order to join the profession. They gain a set of knowledge and associated competences during their studies. But the discussions held with PTs in this research would support the claim that it is the participation approach which develops the attributes of a professional. PTs highlighted that their formal learning does not relate to the jobs that they are required to undertake after qualification.

The PTs described their learning through communities of practice as outlined by Lave and Wenger (1991). The PTs detailed how they are supported in their development from a newcomer through to being an old timer. Skills such as management and leadership are gained through observation and guidance of those around them. And the essence of professionalism and professional practice is learned by observing role models and through reflective development across their career.

However, as well as these approaches of initial training and education and workplace modelling, the PTs described their routine engagement with formal learning and access to information to make sure that they retained competence and stayed up to date. This is described by Cuyvers as self-regulated professional learning (Cuyvers et al., 2020), explaining how individuals take responsibility for their own learning and drive this through in practice.

The gap raised by this is a lack of consistency and structured career development across the country. All PTs continue to learn but may choose different things, work in different ways and model their behaviours only on local practice. This is likely to be another element of the lack of a clear, defined role for PTs working in community pharmacy. In their exploration of workplace learning, Billett (2001) and later Bryson (Bryson et al., 2006) comment on the consistency of approaches to learning within a workplace, but the challenges raised by the different work environments, support provided and ethos of

learning across a range of institutions. Hilton (2005) describes this as attrition where a lack of consistency in learning opportunities results in a negative effect on ability to learn professionalism. These challenges are clearly in place for PTs across England.

I propose that the development of a work place curriculum is a potential route by which these three elements can be linked together explicitly, providing a deliberate learning pathway that enables the individual to gain the implicit essential learning through their practice. As a single national provider of learning content and education supervision for the pharmacy workforce, CPPE is well placed to take the lead in this development working in partnership with other agencies.

The participants in this research had all undertaken their initial qualification as workplace study whilst practising in community pharmacy. Throughout their pharmacy careers they had learned to learn whilst working, linking their theoretical knowledge to their practice with the support of their colleagues and mentors. Their conversations centred on ongoing learning as something which was part and parcel of their role. It would be interesting to explore whether this work-based approach to learning was linked to their enduring practice of ongoing learning at work.

6.5.1 Importance of knowledge

One claimed root of a profession is having an area of knowledge which is owned by, and unique to, that profession. However, this was not something that my participants demonstrated that they recognised or appreciated as relevant to the PT. The PTs who engaged in focus groups and interviews with me knew that they had a level of knowledge and specific knowledge which was special to them and their roles but they did not see this as part of their professional status.

They made a definite link between being a PT, registration and professionalism. Although they knew that they had a common qualification in order to join the register, they did not make explicit links between the qualification that they held and their professional status.

The research undertaken by Schafheutle and Jee (Schafheutle, E et al., 2017) may offer some insight into this perception from my participants. They found

that community PTs considered that the training for their qualification did not link closely to their role – despite the course being delivered part time whilst the individual was working. It included elements of practice that were no longer relevant, such as extemporaneous dispensing and had limited or no content related to professionalism and accountability.

However, it was also apparent that PTs knew that what they learned was a specific area of the wider learning and degree level study undertaken by the pharmacist. There was no part of their learning programme which was unique to the PT and was not covered by the pharmacist. It is possible that this lack of special knowledge, owned just by one profession, may be a factor in this lack of connection between expertise and professional status.

Following Schafheutle's report on the initial education and training of PTs (2017), the GPhC has introduced new IET standards. These standards include teaching of professionalism to PT students, forging stronger links between the employer and the educator and a stronger focus on taking responsibility for the final accuracy check of dispensed medicines. The IET standards for the pharmacist do not include content on the final accuracy check of dispensed medicines. This may start to create a distinction in the purpose of each role and the specific knowledge needed for practice. This change in the PT IET may embed a formal recognition of professional practice and a set of knowledge and skills which are owned by the PT profession into their taught qualification.

This change to IETs will start to introduce formal training on professionalism and so enable the second stage of professional socialisation.

6.6 Post qualification

Whatever route participants took into the profession, there was considerable discussion about the nature of the work that they undertook subsequently. Participants described the challenges that their work brought to them and their ongoing development within these roles. The changing nature of working in community pharmacy was discussed. More pharmacies use transient pharmacist locums and consequently PTs are taking on roles as store managers to maintain service levels and standards. They also discussed the changing patterns of staffing levels with a move from one pharmacist and one dispenser within each practice to larger practices with more staff who were needed to meet the needs of higher volume dispensing (average items dispensed has increased by 17% over the period 2010 to 2018 (NHS, 2020)), and teams of PTs working together to ensure that patients received their medicines on time.

Participants discussed the different approaches they had taken to meeting these challenges and shared a sense of determination in doing so. They described elements of selflessness in their practice; making sure that the patient was well cared for and looked after even if this was at personal cost. For example, giving up their own time to visit patients at home or staying longer at work to finish a task because they recognised it was essential for a patient's safety, health or well-being. They contrasted this with other shop staff who could simply clock off when the working day was over.

Learning was a fact of life for all the cohorts. Not only did they talk directly about the approaches that they used in order to keep up to date, they also described in their wider conversations how they had engaged with learning and with education in order to develop their careers. Very few of these conversations focused on formal, accredited learning; once they had gained their PT qualification the groups did not share stories of engaging with other recognised courses.

The most common post-qualification training course that PTs discussed was the accuracy checking programme. This course was provided by an accredited training provider, not a further or higher education institution, and sought to demonstrate the capability of the PT to check that dispensing had been done

accurately; effectively that the medicine which had been dispensed matched the medicine which had been prescribed. Gaining this qualification required that the PT could demonstrate a consistent ability to perform without errors in their practice. Verification and validation of this ability came from an external agency and the supervising pharmacist and there was no element of self-checking, reflection or link to ongoing development. Although the achievement of the accuracy checking qualification increased the status and responsibility of the PT, gaining the qualification did not relate to professionalism in practice.

Engagement with informal learning and taught courses was essential for safe practice and considered routine. It was a requirement of registration and an expectation of their employers. However, none of the participants talked about being given time at work to engage with learning. There was an expectation that the individual would do this in their own time because it needed to be done.

When we talked about the reasons for people becoming PTs it had become clear that one of the enablers for the role was that people didn't need an academic qualification to do it. It is perhaps less surprising that this complicated relationship with formal academic learning remained apparent in this group. Indeed, one participant stressed that he was not very good at learning, he just needed to know how to do his job.

This individual offered particular insight to the complicated relationship with academic and workplace learning. The PT was leading care services for a series of nursing homes and discussed how the care home team relied on him to help them plan for CQC visits, medicine safety audits and compliance with regulations. In order to take on this role he had undertaken a number of formal courses related to audit, compliance and legislations. And he had participated in joint training sessions with colleagues across the care home settings. He had engaged regularly and routinely in learning. Despite this he claimed that he was not good at learning. It was apparent that he saw a clear difference between the learning which he did on the job in order to be competent, and engagement with formal academic learning.

For PTs, engagement in ongoing learning was focused on making sure that patients were safe, it was an element of patient-centred professionalism that was surfaced in the focus groups and ratified in the interviews. This ongoing

learning was also something that was perceived as completely routine and engrained in their practice. It was discussed in a matter of fact way and with an assumption that everyone was doing it because that was simply the nature of the job.

PTs made no connection between this routine, patient safety focused ongoing learning and the CPD that they were required to undertake by the GPhC. They described CPD as learning that they undertook because they were told to by the GPhC. They had to show the GPhC that they were undertaking CPD, confident in having the right knowledge and working to make sure that they continued to know it. This made sure that they could stay on the register. But they chose to learn because they knew it made their patients safer.

6.6.1 CPD and learning

The technicians talked about burdens and obligations when asked about the formal process of recording CPD, which they are required to do to remain on the GPhC register. They described this as something that had to be done and shared stories of this being onerous and more akin to a process which had to be followed properly in order to remain registered rather than one which encouraged learning, development and career expansion. There was a clear separation in their conversation between routine learning, which they did because it improved patient care and their own personal enjoyment of the role, and recording of CPD because this was required by the regulator. They talked about methods that they used to make sure that they had something to record which would meet the standards set by the GPhC, but they also talked about the pressure that was associated with this, both for other PTs and for their pharmacist colleagues. There was no link made between the need to record CPD and their professional status or practice or, indeed, to improvements in patient care.

This perception of the burden of CPD may be changing. My research was undertaken at the same time as the GPhC was starting to introduce a new system for recording CPD which reduced the numbers of steps in the process and asked the participant to record what the outcomes for patient care had been. Members at one focus group had engaged in the pilot phase of this new

system and commented that it seemed to be easier and more relevant to real life and practice. This simplification was seen as a positive service change.

Recognising a need to continue to learn throughout a career is considered to be a mark of professional practice (Beardsley et al., 2000; Boyle et al., 2007). Researchers have linked developing professionalism with maintaining a reflective log of learning and actively linking this to the development of the individual as a professional. For my participants there was a gap between recognising the need to engage in ongoing learning, which was clearly linked with improving patient outcomes, and the outcome of this learning captured in a portfolio of professional development. The new recording system from the GPhC seeks to introduce a higher degree of reflection to the CPD recording process, so may start to lessen this being seen as a burden and move it to being a positive and useful resource.

The stark contrast in attitudes that contrasted learning with CPD surface the tensions around managerial professionalism (Sachs, 2001). In this concept Sachs describes an external agency which describes the required attributes and roles of the profession; it is imposed rather than owned. The clear separation in thinking and conceptual acceptance of CPD compared to lifelong learning suggests a resistance to having external standards and descriptors of professionalism imposed.

6.7 What supports and hinders the development of a Pharmacy Technician as a professional

When considering the factors that act as barriers and affordances to the development of professionalism for the PT, the same factors are present on both sides. Future developments will require careful management of the balance between these factors.

The factors that support the development of the profession were the pharmacist, the system and the wider community of PTs. The barriers to development were the pharmacist and the system. These factors are now explored in more depth.

6.7.1 Affordances for the PT

There were repeated instances where a pharmacist was listed as the catalyst for career development and motivation to train to become a PT. Pharmacists were described fondly as old school mentors who oversaw learning and supported them as they became PTs. Praise from a pharmacist brought added value and there was clear respect for the pharmacist and the pharmacist profession.

The pharmacist was cited as the person that the PT turned to for career guidance, with examples given within community pharmacy practice and for those who had experience in pharmaceutical industry and primary care roles. The pharmacist was a trusted individual who understood the working environment and could offer valued insight into the skills and future capabilities of the PT.

Good pharmacist practice was seen as that which encouraged the PT to learn for themselves and to propose solutions rather than simply ask for the answer to a question. One PT, working in a primary care role, referred to the pharmacist advice by telephone as her “phone a friend” support showing the nature of familiarity and nurture that she gained.

There were clear instances in the conversations where the pharmacist sought to enable the PT and to develop their role, competence and confidence. This was seen most clearly with the CT group and, in interviews, with MT1. In these cases the pharmacist encouraged the PT to work out a solution to challenges that they faced by themselves, and then to discuss it with the pharmacist to gain validation of their conclusions. It could be seen that this resulted in a sense of pride and self-belief for the PT, greater trust and confidence in the pharmacist, and a willingness to continue to learn and develop as part of the pharmacy team. Whilst there remained a hierarchy in these situations, it was one that was founded on respect and shared learning, not simply rank.

The system was also a factor that enabled the development of the PT role and their professionalism. The introduction of regulation in 2011 resulted in the stricter definition of the role of the PT and the responsibilities that could be

undertaken by someone in this position. This had led to an increased range of duties for the PT within the practice and more PTs being encouraged to undertake their accuracy checking qualification. As a consequence more services were offered by the pharmacy team and more opportunities were available to the PT. In the short time frame of this study, half of the PTs who were interviewed had changed their roles in the period that elapsed between the focus group and the interview.

There was a sense of freedom for the PT to practise outside of the confines of the pharmacy building. Examples were shared of working to support care homes, to attend meetings with colleagues in general practice and to advise prescribers on medicines supply issues. Each of these was enabled by a system that recognised the knowledge and capability of the PT.

6.7.2 Barriers for the PT

As well as an enabler, the pharmacist could also be a barrier to the development of the PT. This came from deliberate limitation of the individual, the power to determine the scope of the role, ignorance and poor practice.

CT6 described two examples of this from her own experience. When she worked in the pharmaceutical industry her progression was limited because she was a PT and, despite being asked to undertake particular duties, she would not be remunerated for these as she was not a pharmacist. She further shared her experiences of having her accuracy checking status removed during her maternity leave. Owing to ill health she was not able to engage in periodic reassessment of her accuracy checking competence. As she then took a period of maternity leave, she exceeded a time limit set by her employer for reassessment and so lost her accreditation. There is no regulatory basis for this reassessment, it is imposed by pharmacists.

Within the focus group conversations it was apparent that the hierarchy of pharmacy practice was a factor for the PTs making it clear that they knew their place. Each focus group stressed the concept of the PT not stepping outside of the boundaries of their role and being explicit that they were not a pharmacist.

The system was also a barrier for PT development. This came through deliberate limitation of the individual, for example PTs who worked for a major supermarket explained that that employer had now changed its terms of employment to prohibit pharmacy staff from undertaking the qualification to become a PT. This was not just a refusal to fund the course for its team, it forbade its employees to self-fund the course for their own development.

There was also a more subtle barrier to PT professionalisation through the use of language. Although this study did not set out to look at language and how it is used, there were repeated occasions where the words which were used and the way that they were understood and interpreted by both me and the participants were central to understanding of concepts

The relationship between the pharmacist and the PT was a clear factor in the conversations that were held in both the focus groups and the interviews. Derrida proposed the concept of différance (Derrida, 1981) which considered the way that language is used to reinforce status and hierarchies. This was evident in use of language and in barriers to developing practices through my exploration. Each article that I read referred to “pharmacists and PTs”, with the pharmacist always coming first in the sentence, followed by the PT, driving forward an implicit priority for the pharmacist over the PT. This mirrors the standard approach in NHS publications to refer to medics and other clinicians, placing priority on the role of the doctor.

The place in the team however was not necessarily seen by the PTs as being subordinate to the pharmacist. Many conversations and examples from practice related to the PT describing occasions when they saw their position as being a peer to the pharmacist, or to other members of the health care team. This confidence in their role, responsibility and purpose suggests to me that my participants knew that they had a specific place and purpose but did not feel that they could claim it. Indeed, this inability to claim the place and purpose was sometimes referred to explicitly by participants who made comments such as “we have to be clear with people that we are not pharmacists”. Perhaps it was easier to define themselves by what they were not, rather than what they were.

Considering earlier discussion about a lack of awareness of what the PT role was, these conversations suggested that the PTs were defined by what they

were not. This recognition of a need to claim the role started to develop during some of the focus group conversations, with the most explicit example being at the end of the London session where one participant summed her engagement in the evening up by saying that from that point on she was going to introduce herself as a PT, rather than being ‘from pharmacy’.

The role of the PT is growing and developing, and their remit in the pharmacy team is expanding. An active and explicit recognition of what the role is and what the individual can do is essential for this to become the norm across the NHS in England. The role of the PT is invariably linked to the work of the wider pharmacy team, but neither of the professional members of the team needs to be defined by the other.

6.8 Implications for professionalism and the Pharmacy Technician

6.8.1 Job applications, apprenticeships and the future for Pharmacy Technician recruitment.

One of the later realisations during my study related to the ways in which PTs were recruited to their roles. There were two broad routes that were discussed; referral from a job centre on leaving school or college and applying for a local job with flexible hours as a young parent with small children. In neither of these positions however did the individual apply for a job as a PT. They applied for jobs in pharmacy, perhaps because of an interest in science but in general owing to the convenience of the location and the working hours.

As my participants agreed, they had not chosen to be PTs. Some other agency had recognised a skill set, or behaviours and had encouraged them to learn, develop and join the profession.

Since I started this exploration of PTs and professionalism, the GPhC has undertaken a review of the Initial Education and Training standards for PTs, agreed a new qualification and a submission has been made to the Skills Agency for a PT apprenticeship role. These moves are potential game changers for PTs.

The new qualification is more closely built around the role that PTs currently undertake. It includes a greater emphasis on clinical knowledge and reasoning and a lower emphasis on the technical elements and the manufacture of medicinal products.

The apprenticeship role means that potential PTs will now be able to apply for a PT apprenticeship – jobs will be advertised as apprentice PTs which in turn offers greater opportunities for the development of professional socialisation.

6.8.2 Importance of role models

Professional socialisation requires a consistent demonstration of professional practice by the members of the profession in order for the newcomer to recognise what this practice looks like and how they need to behave in order to become a member of that profession. As Beardsley et al (2000, p.100) state

> "Practising pharmacists should be aware of their critical role in professional socialisation. Special care must be taken to avoid creating situations of inconsistent socialisation."

They argue that pharmacists, and I extend this to PTs, should do their best to contribute in a meaningful manner. The GPhC offers its guidance to tutors for pharmacy professionals (GPhC, 2017a) and provides an outline of what is needed, stating that good role modelling is required at all times by the tutor.

For my participants, professionalism had been learned by observing poor practice as well as good practice and so it was apparent that this consistency of good practice is not yet in place in routine pharmacy practice. PTs, and other professionals, need to recognise that they are each role models for others. They need to engage in conscious thought about their actions and seek to ensure that they are consistent in the way that they work, engage with patients and the public and with other health care team members. The importance of role modelling to learn professionalism was stressed by Byszweski et al (2012) who found that students recognised it as the single most important factor for their learning of the concept. As an individual, accepting that you are a member of a profession and committing to acting in a way that is in accordance with the written and implicit code of practice for that profession is a key step in becoming a member of that profession.

6.8.3 Developing a sense of identity, pride and professionalism

The role of the PT is relatively long standing, but it has only been recognised as a profession through regulation since 2011. PTs had not actively chosen the career initially but having taken the roles recognised the importance and impact of their work and described attributes of professionalism in their conversations. This recognition and acceptance of status was apparent throughout my focus groups and follow up interviews. There is an appropriate sense of pride in being a PT, accepting that it is a special role, worth doing, which adds value to the health care of individuals and the wider population.

At each of the focus group sessions the PTs who attended were keen to talk and to share their perspectives on their roles. They were eager to hear the stories that their colleagues told and to find out how other people had become PTs and developed through their careers in pharmacy.

There was a real sense of pride in what they did and the importance and benefit of their work in the pharmacy, coupled with a recognition that this was often invisible both to the customers of their pharmacies and to their colleagues and managers.

Whilst there was a sense of pride within the role, this was not extended to a sense of pride in a profession. There was no sense of appreciation of a national identity for PTs, what shared core values the profession espoused or where the role could take and develop those who undertook it.

There is a national association for PTs, which has less than ten percent of the profession in its membership. This lack of identity and feeling part of a wider community may be one of the reasons for this. For a new profession with practitioners who do not work together, or engage with each other, on a regular basis, the formation of an identity for the role which is recognised and understood publicly appears to be a need.

From these groups it was clear that PTs believe that professionalism is about the way that people work. It is clearly linked with high standards, high quality and trying to put the patient firmly at the centre of their care: professionalism for a PT is a 24-hour, 7 day a week state of being. It is not something which starts

when they arrive at work and which they can then walk away from at the end of the day.

The public expects that they will get accurate and up to date information, medication and therapy when they visit a pharmacy. And this expectation in turn means that the pharmacy team is obliged to keep itself up to date. Although the groups did not recognise that meeting this obligation was a professional requirement, they did demonstrate that they actively engaged with ongoing learning. They recognised that this was required by the regulator and that it was one of the things that made a difference between those who worked in the pharmacy, and those who were pharmacy professionals.

The PTs recognised that they demonstrated professionalism through their attitudes and behaviours which fitted within the concepts and models of the trait theory approach for professionalism. There was little acceptance from the PTs that they felt that they had sufficient knowledge for this to be part of their claim to be professional. The lack of knowledge was supported by the lack of conversation about common learning activities to undertake after qualifying, with no members of the groups talking about common standards to enable management, leadership or ongoing clinical development within their roles.

There was a perception of a lack of a social mandate for their role to be a profession. The PTs knew that they were perceived in a different way by others, for example the mother telling her daughter that she would have to keep herself clean now she had a job in a pharmacy. However, there was no acceptance or recognition by the group that this status was real or deserved.

The members of the original professions were the elite of society and this sense of being part of an elite is an enduring aspect of concepts relating to the word ‘professional’. It is sustained by research into professionalism and professional behaviours focusing on the wider public good, positive outcomes and altruistic intentions. Within this investigation the study considered a group of people who have become members of a profession through regulation. Throughout the conversations in the focus groups and interviews there were two clear strands. Firstly, participants recognised that the PT role title was protected by regulation. Only those who met the entry standard, continued to act in an appropriate way and engaged in mandated CPD could continue as PTs. This was recognised

and adhered to but was described in a language of necessity; they did what had to be done.

Secondly participants talked about a job that was worth doing. They talked about going the extra mile, treating all patients with respect, taking responsibility for their actions and learning so that they could continue to offer the best level of patient care. Returning to the ten attributes of professional practice proposed by Beardsley (2000), essentially the focus groups and interviews repeatedly found how PTs demonstrated these attributes in their routine work.

6.9 Reflections on my own research journey

Carrying out this research has shown me that professionalism means different things to different people, that it relates to working context, upbringing, self-perception and the views of both society and regulators.

Similarly, my understanding of research has changed. I recognise that research is not clearly delineated into quantitative and qualitative, or indeed mixed paradigms. These are broad terms that try to explain a mindset, or conceptual thinking. Choosing to follow a qualitative approach did not offer me a simple route into finding that approach easy. Throughout my research I have been challenged by a desire to say what my work is proving, to comment that what I have learned from talking to a small group of engaged PTs is somehow representative of the whole PT community, and indeed that learning about this one small group of new professionals can somehow provide a framework for understanding other new professional groups. I know that this is not the reality of my research. What I set out to do, and what I have done, is to take the time to actively listen to people who wanted to tell me about their experiences and practice. I offered a focus and they grasped it. They became engaged and enthused to talk about their work, their personal development and the roles that they fulfilled and to relate these to a concept of professional practice. Presenting my early outcomes to a group of researchers across health networks at a Leeds Education conference in 2018 demonstrated relevant messages for other new professional groups as they undertake similar routes into new roles within existing teams. There is clear scope for further research.

I found it difficult to find a single narrative to share in this thesis. Four focus groups and eight interviews provided me with so much data that I could not include everything in this one piece of work. Trying to immerse myself in the data and find out what mattered most to the PTs who came along, rather than to me, required me to constantly revisit the data and challenge myself to look at what it was saying rather than what I wanted to see. The outcome in this piece of work is a narrative which I think represents fairly what the 19 PTs who gave up their time to talk with me had to say. I believe that they will read this and recognise the truth of their perceptions and conversations and that they will gain a sense of pride in themselves for having taken the time and found the courage to join in with this discussion.

At the end of this work I have learned more about myself and my own reflections on professionalism, I have improved my ability to listen and to listen actively to others and I have gained a series of skills in undertaking a qualitative piece of research. I still find it hard to accept that I may now know more about professionalism than others do, although I know that this is an important and early piece of work and the first that has taken the time to really start to try to understand what community PTs think about the way that they work, the impact of regulation and what it means to be part of a new profession.

I started this study with an explicit intention to develop learning resources which were relevant to the PT workforce. Through this work I have gained an insight to what is needed to ensure relevance, identified a need to develop new materials relating to professionalism and practice which consider how it is taught and demonstrated, not simply the knowledge, and I have influenced national policy related to workforce development.

6.10 Strengths and limitations of my work

At the time of inviting people to my focus groups there were around 18,000 PTs on the GPhC register. The data on their working location was not available, but it seems likely that the majority of these did not work in community pharmacy, which was the target group for my research (GPhC, 2019). I invited community PTs but my focus groups consisted of those who saw themselves as working in community pharmacy. The broad make up of those who chose to attend my

focus groups included mostly those who were working in community pharmacy practice. Three PTs came who worked in a wider primary care role and three PTs came who had moved to work in secondary care practice but who wanted to share their experiences of working in community pharmacy and felt that my research was still relevant to them and to their perspectives. This could suggest that my groups were made up of PTs who are more committed than others to their role and their profession. And so this needs to underlie any inferences I may make through reading this work and drawing conclusions. Qualitative research does not usually seek to be representative and the random, rather than purposive, sampling approach that I used helped me to gain a good spread of perspectives and opinions. Further research, from a different paradigm, could explore whether the views that were shared with me represented the wider profession.

Exploring the perspectives on professionalism from those who are pushing the boundaries of the profession, taking on new roles and occupying the professional space offered to them, gives good insight into what professionalism could mean for others. And since this research is trying to determine how a new professional group starts to occupy its new professional identity, then these participants have something valid to say which is likely to be of interest and potential use for their professional peers. It is also key to highlight that this group shared similar stories of how they became PTs. They did not choose the role but fell into it. Their stories of how this then resulted in role progression and personal development into professionals have validity and resonance for other members of their profession. None of my participants described privilege from the start of their professional journey.

Describing some of the context related to the focus groups themselves also shows how engaged my participants were, and the sense of value that they seemed to gain from the conversations with their professional peers. Although I had told all of my participants that the focus group would last for up to 90 minutes and let them know when the conversation had finished, at each event the participants carried on talking about the topic even after I had completed the formal group discussion. They asked me questions about what I considered professionalism was and continued to spark off each other with ideas about what it may mean for them. These ongoing conversations lasted for up to half

an hour after the focus group itself had closed. Two of the participants sent me follow up emails the next day, not only to say thank you for including them, but also to share additional reflections they had on their journeys home. Half of the participants of the focus groups offered to participate in the telephone or face to face interviews and wanted to know more about what other people had said in the other focus groups. And when I started the interviews by asking if they had chatted with anyone since the focus groups, all but one (who was on maternity leave) described conversations with colleagues about professionalism after the focus group itself. This suggests they found the topic relevant; it related to them, their thinking and the way that they want to work in the future. I consider this relevance to my target audience to be a strength of my research and I continue to appreciate and value the energy and enthusiasm that my participants brought with them.

Although patient care was an emergent theme when I analysed the data, I did not recognise this as such during the focus groups or interviews and so I was not able to ask participants whether they saw links between unprofessional behaviours that they saw in practice and diminished patient care or safety. So whilst I have assumed an implied link that professional practice results in a better level of patient care, I have not explicitly asked my participants whether they see this as well, or whether they have any evidence to support this. This offers scope for a follow-on research project.

My work is inward looking and only takes the views of pharmacy professionals. This is both through the focus groups consisting of PTs and from my own practise as a pharmacist. Whilst I consider this to be a strength of my study in that it gave a voice to this group of professionals, it does mean that there is no external sense check on whether the views and opinions of PTs captures the dynamic relationships of the practice setting.

6.11 Summary

This chapter sought to close the loop on this research programme. It shared the interpretation of the investigation itself and related this back to the wider literature base so that it was clear how this body of work adds to what is known and engages a richer awareness and understanding of the PT's professionalisation. Additionally, it considered the specific impact of the researcher, addressing questions raised in the consideration of the selected methodology. Finally, it considered aspects relating to research quality, demonstrating the importance of this work and the potential areas for future investigation which could build on what has been learned.

Chapter 7 Conclusion, implications and summary

This final chapter returns to the research questions themselves to offer clarity over what has been found out and learned. It considers what the implications of this new knowledge may be for the profession and for development of resources to support members of the profession. It proposes how approaches to education may be revised to meet the identified needs of PTs.

The research has already started to have an impact on practice both within CPPE and at a national policy level and this is summarised in this chapter. Gaining an understanding of this group of PT professionals has influenced the national strategy for their support, development and future recruitment.

Finally, this chapter proposes future research that could be undertaken to build on what has been learned and uncovered as this exploration progressed.

7.1 Concept of professionalism

The first section of the research question considered what professionalism meant to PTs and whether this was affected by how long the individual had been working as a PT. It explored whether PTs linked CPD with professional status or practice and how they met the requirements to keep learning throughout their careers.

It was clear that community PTs associate professionalism with high standards of work and caring for the patients and people who use their services. They see professionalism as something that guides their decision making both within the work setting and outside of this setting as well.

Regardless of how long the PT had been working in practice, they shared a common concept of professionalism. This was something that was recognised as an essential criteria for anyone working in pharmacy practice and was highlighted through descriptions of old school individuals who had stressed behaviours, attitudes and standards that were expected from the pharmacy workforce.

The study design meant that the output was largely driven by participants. Future approaches that seek to explore the specific impact of the introduction of

regulation could tease out whether this changed concepts of status or self-identity. The focus group participants recognised that it made them think more about their practice, but this was linked to fear of removal from the register rather than a positive influence on status or self-belief.

Learning was an enduring and accepted part of their practice, but participants talked about CPD and ongoing learning as two separate areas and did not make links for themselves between the two. CPD was seen as mandatory study in order to enable the individual to remain on the GPhC register. It assured a professional status but was not identified as lifelong learning or necessarily helpful to undertake their role.

PTs talked about the approaches that they used to enhance their knowledge and competence in the workplace. This was aspirational learning for them which they enjoyed engaging with and were eager to continue – one participant even asked my advice about new learning opportunities at the end of a focus group.

Perhaps these conversations showed that the participants saw a disconnection between the CPD that was required by the regulator and the learning that was needed to improve patient care. For them professionalism was demonstrated by the care that they showed patients and so they made explicit links between learning and professionalism.

PTs met their CPD requirements through constant recording of their learning and then periodic review of the learning they had done which fitted most closely with the restricted recording system offered by the regulator. Some had engaged in a pilot of a new system of recording.

PTs learned through a variety of approaches describing some formal workshop learning but predominantly discussing learning on the job both through learning from colleagues and from reading written materials. This insight enables CPPE and other education providers to consider new routes of engaging with PT learners through considering how learning on the job is linked to learning throughout a career.

7.2 Barriers and affordances

The second research question considered what enabled PTs to develop in their professional practice and what the obstacles to this development were. Although the PTs used the expression CPD to specify their annual written records for the GPhC, they talked extensively about the role that ongoing learning played in their jobs and their capabilities. The affordances that they described related largely to the teams that they worked in. References were made to working with each other, learning together and sharing ideas with each other as elements that drove their learning and the work that they did. There was a clear sense of encouragement from the people that they worked with and supported. In many instances the pharmacists who worked alongside the PT was also recognised as an affordance for their engagement with learning. One PT talked about the pharmacist as her 'phone a friend' for when she needed support and advice, others talked about the pharmacist encouraging them to learn and be inquisitive by always asking what they considered the answer was to a question before progressing to answer it.

A similar model was apparent with professionalism. The team that the PTs worked with were drivers for professionalism, providing role models for their work, demonstrating how to undertake tasks and offering a sense check that they were acting and behaving in an appropriate way for their practice environment. It was clear that PTs looked for professional behaviours in a range of environments and then contrasted what they saw with how they sought to behave in their own practice. Whilst they were aware of guidance from their regulator, they gained their knowledge of professionalism in practice from their own lived experiences.

Pharmacists were however also found to be the barrier for both ongoing learning and professionalism. Some of this may be down to oversight, for example a lack of awareness that PTs did not have management skills training in their qualification seems to result in PTs taking on this role in practice without being offered training to enable this. In other areas however it seemed that the pharmacist was actively deciding to limit the learning potential of the PT. This was perhaps seen most clearly in the case of CT2 who was prevented from undertaking a role in the pharmaceutical industry because of her qualification

and was then prevented from maintaining ACPT status when on maternity leave.

It was also clear that pharmacists were barriers to learning professionalism in practice. PTs described locum pharmacists who came to work in their practice and displayed unprofessional behaviours. Whilst the PT was able to recognise that the behaviour was inappropriate and so could make a conscious decision not to act in that way, the pharmacist was not offering effective role model behaviours that would demonstrate what good looked like.

Through my research I have recognised that professionalism, being a professional and being part of a profession are related but separate concepts. It would, perhaps, be simpler if we had a new language for these concepts that described them separately and then kept them within their own neat confines.

There is no single understanding of what a profession is. Indeed, the conflicting ideologies of regulatory professionalism and person-centred professionalism have been recurrent themes throughout this exploration. PTs recognised that they had become members of a profession because of regulation, but their discussions explained how they owned professionalism themselves and repeatedly demonstrated it through caring for those who used their services.

7.3 Implications of these findings

The third and final research question considered what the outcomes of the study meant for the future of the profession and for practice.

My study was a first of its kind exploration of perceptions of a small group of PTs who worked in community pharmacy. Further research is needed to determine whether my findings are representative of the wider profession and relatable to different sectors of practice for PTs. Whilst I believe that there is likely to be overlap between what I have learned about developing a new profession for PTs and other current development of new professional roles, this is another potential next step exploration for research to ascertain whether this is the case.

More information is needed on whether there is a link between unprofessional behaviours and diminished patient care or safety as this was a theme which

emerged during my analysis of the data and so I did not explore this explicitly in my research. I have assumed a link, but this may not be the reality.

Considering my findings in light of the wider evidence base, I believe that practice could be improved by ensuring consistency in professional socialisation across pharmacy practice. I found a strong message that where there were excellent role models who clearly and consistently demonstrated their professional practice and values in their work, this resulted in positive outcomes for other practitioners and clarity in building a professional identity. Understanding the implicit fiduciary contract of professionalism through observing the actions, attitudes and ongoing development of peers and reflecting on this to make it explicit for individual and team development will, I feel, cement the individual's awareness of their own status as a member of a profession.

The GPhC revised the initial education and training standards for PTs (GPhC, 2017b) to make professionalism part of the core qualification, enable PTs to offer an accuracy check, encourage multidisciplinary team learning and ensure links between employers and educators for this work based learning programme.

As the qualification is work based, there is a concurrent need for pharmacists and other pharmacy team members to recognise the need for them to change their practice for my proposed changes to be feasible. If pharmacists continue to act in such a way that PTs learn from observing poor practice, it will make it more difficult for PTs to build and accept their own professional identity.

Having engaged PTs from a range of community pharmacy backgrounds and experience in my research, of different genders and ethnicities, a range of ages and years of experience, I believe that they demonstrated that they are a relevant and valuable professional group. They had pride in their role and remit and could provide multiple examples of how they demonstrate professionalism in their practice. They did not have a strong sense of identity as a profession however and this is an essential area to focus on for further development of this group and their role. This is an area where the CPD opportunities from CPPE can play a part.

The concept of professionalism proved hard to describe for the participants in my focus groups, but they demonstrated a clear understanding of different components that have previously been identified in the research as underpinning it. They recognised the privileged knowledge that they gained about those using their services and the place within health professions that they held. They also felt that this was not widely recognised. This provides the basis for developing and refining learning resources.

It is clearly difficult for a profession which works so closely with, and is often line managed by, a second related profession to claim its own space and identity. From this early work it seems that this recognition of identity and exploration of particular roles, responsibilities and obligations is needed for the profession of the PT to grow and develop.

7.4 Implications for development of education

In chapter six I proposed that there was a need for a work place based curriculum to be developed which enabled and directed the development of professionalism for PTs. This is aligned with other research and the drive to explore ways of teaching professionalism which were outlined in chapter two. This curriculum offers the opportunity to assure learning of professionalism that meets the needs of this patient facing profession.

For PTs I believe that there is first a need to create a white paper for PT professionalism, as Beardsley (2001) did for pharmacists. At its simplest this would describe the ways in which PTs demonstrated that their practice was that of a professional. It is important that PTs publicly claim their professional space.

Hilton and Slotnick (2005) proposed there are three components to the learning that is needed for PTs to engage with; reflection on practice, consistent learning opportunities and reduction of attrition. Firstly, there is a need to recognise the professionalism which has been gained through practice and experience. This learned professionalism was clearly shown throughout the focus groups and interviews that I hosted. For PTs to recognise this professionalism, it is important that an appropriate reflective process is developed which supports the PT in recognising where skills and competence have been gained and where gaps still remain. It is then important to consider how opportunities for

development of professionalism in practice can be defined and provided for newcomers to the profession. It was apparent from this research that serendipity played a part in PTs finding opportunities to see, experience and learn professionalism. When considering the development of an entire workforce, these opportunities must be routine and consistently available.

Finally at the same time as opportunities need to be made routine, it is essential that poor practice be reduced as far as possible. Even in the small group of PTs who joined in this research investigation, there were repeated stories of learning from poor practice. Hilton refers to this as attrition. PTs have the opportunity to recognise that they are role models for others who join the profession. They must be supported in learning how to act as explicit role models of professional practice.

As the new system of revalidation is rolled out across the pharmacy workforce, making the links between the routine learning on the job which improves patient care and reflection on this to demonstrate the impact of the individual could reduce the gap between learning and CPD which was seen in this research. Ongoing learning is a bedrock for healthcare professionals and PTs will benefit from recognising that this is part of their continuing professional development.

7.5 Impact of my research

Since starting this research I have engaged with networks related to education, pharmacy and professionalism. This has already resulted in me sharing some elements of my research and being sought out for perceived expertise and specialist knowledge in this area.

This has included debating professionalism and requirements for revalidation with Roy Lilley (an acclaimed speaker and author of NHS management resources) at an event sponsored by Health Education England and arranged by the General Pharmaceutical Council in November 2018. I have been invited to the partners' engagement forum by the Association of PTs UK since March 2019 to support their work in engaging PTs with lifelong learning and linking this development to their own practice. I have been invited to participate in further

research from HEE and the APTUK that seeks to build a scope and concept of foundation practice for PTs.

These different areas show that my research is already starting to have an impact on the learning and development of this professional group.

Most recently, since April 2020, I have been contributing to national career and engagement planning strategies from NHS England and HEE. There is a stated drive in the NHS People Plan to increase the number of PTs and pharmacists and a national lack of awareness of how to do this. My explorations of what attracts PTs to the role and the general lack of visibility of the position has resulted in different approaches to recruitment, role promotion and the ages that adverts are aimed at. My research found that PTs joined the profession after starting a family which means that adverts which focus only on school leavers would limit opportunities to identify suitable applicants. I have also reminded people constantly to think about their use of language and the accidental downgrading of the PT in their literature with one of my supervisors indicating that she has now revised the order in which she introduces different health professions in sentences in her teaching.

The direct impact of this research is most clearly seen within learning development plans at CPPE, my employer. Based on the findings of this research, we have now commenced the development of a national curriculum to underpin a bridging programme for PTs across England, working in partnership with the APTUK. This will enable all PTs to undertake a consistent formal learning pathway meeting the outcomes of the new IET standards and encompassing management, leadership and professionalism. At the same time we are creating a PT fellowship role within the leadership team of the organisation. This role will follow a 12 month structured leadership development curriculum, building national networks and demonstrating high level role model behaviours for the PT profession. The scope of this role has been shared with colleagues at APTUK, who are keen to work with CPPE on crafting the content of the year, and at HEE, who are exploring setting up a similar role within their own organisation. APTUK have shared the role with colleagues in other UK countries and are exploring a similar position with HEIW (Health Education and Improvement in Wales).

7.6 Interest and relevance for the future

Through my exploration of the literature relating to professionalism, I learned that it is a concept which changes with time and culture. At the moment professions are strongly associated with regulation and regulatory bodies. Indeed, it was the regulation of the PT role which conferred a professional status on this group of health care practitioners. Across the NHS in England there are comparable moves to introduce new professional roles, which will take on some, but not all, of the tasks of other professions. Nursing associates have been introduced to take on some tasks of nurses, and physician associates have been introduced to take on some tasks of doctors. It seems likely that there will be similarities between the development of these groups as professions and the path which has been taken by PTs. Those who are involved in the education of these new professional groups may find my research useful.

As the new initial education and training standards are implemented for PTs across the UK and PTs continue to seek recognition of their professional status, my research offers some useful insight and understanding from those working in community pharmacy practice – a group which has been hard to engage in earlier research.

There is a need for effective descriptions and understanding of the PT profession and a commitment to explicit positive role modelling. New professions are being developed within the NHS. It is likely that there is a similar development need for each of them to be shaped as professions and build a shared sense of identity amongst practitioners. Further research could usefully explore this potential commonality.

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Appendices

Appendix One – Ethical approval

Performance, Governance and Operations
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UNIVERSITY OF LEEDS

Matthew Shaw
School of Education
University of Leeds
Leeds, LS2 9JT

ESSL, Environment and LUBS (AREA) Faculty Research Ethics Committee
University of Leeds

8 January 2017

Dear Matthew

Title of study: **Professional behaviours: concepts and barriers for community pharmacy technicians in England**
Ethics reference: **AREA 15-157**

I am pleased to inform you that the above research application has been reviewed by the ESSL, Environment and LUBS (AREA) Faculty Research Ethics Committee and following receipt of your response to the Committee's initial comments I can confirm a favourable ethical opinion as of the date of this letter. The following documentation was considered:

Document	Version	Date
AREA 15-157 Ethics application MShaw 2016 revised post ethic committee review.docx	1	26/07/16
AREA 15-157 MS_Participant information sheet focus group revised post ethics committee review.docx	1	26/07/16
AREA 15-157 MS_Participant information sheet interview revised post ethics committee review.docx	1	26/07/16
AREA 15-157 Risk form M Shaw post ethics committee review.pdf	1	26/07/16
AREA 15-157 Ethics application MShaw 2016 June 19.docx	1	04/07/15
AREA 15-157 Survey Invitation letter.docx	1	04/07/15
AREA 15-157 MS_Participant information sheet focus group May 31.docx	1	04/07/15
AREA 15-157 Participant consent form - focus group.docx	1	04/07/15
AREA 15-157 MS_Participant information sheet interview May 31.docx	1	04/07/15
AREA 15-157 Participant consent form - interviews.docx	1	04/07/15

Committee members made the following comments about your application:

- Your fieldwork risk assessment will need to be signed off by one of your supervisors or an appropriate person within the School of Education.

Please notify the committee if you intend to make any amendments to the information in your ethics application as submitted at date of this approval as all changes must receive ethical approval prior to implementation. The amendment form is available at http://ris.leeds.ac.uk/EthicsAmendment.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be

audited. There is a checklist listing examples of documents to be kept which is available at http://ris.leeds.ac.uk/EthicsAudits.

We welcome feedback on your experience of the ethical review process and suggestions for improvement. Please email any comments to ResearchEthics@leeds.ac.uk.

Yours sincerely

Jennifer Blaikie
Senior Research Ethics Administrator, Research & Innovation Service
On behalf of Prof Michael Thomson, Acting Chair, AREA Faculty Research Ethics Committee

CC: Student's supervisor(s)

Appendix Two – Focus group guidance questions

Tell me your name and how long you have worked as a PT

Can we start by sharing what we think it means to be a professional?

What changed with registration in 2011? Before that you had a job as a PT, then you were working as a professional PT. So what changed?

What do you see as the difference between the professional PT and the dispenser or medicines counter assistant?

Is there a certain knowledge that you need to be a professional?

Is professionalism about behaviour at work, or out of work?

Where do you learn to be a professional?

Who do you model yourself on?

Do you see a link between being a professional and continuing education?

Appendix Three - Interview skeleton questions

As you may remember I am exploring professionalism and what that means from the perspective of a PT, so it covers training, role models, how you see yourself, your identity as a professional, ongoing learning and so on. We talked about these during our conversations in the focus groups. Sometimes it is afterwards that something occurs to you. I know it was a long time ago, but is that something that happened for you? Did you have things that triggered you to think about it afterwards?
Have you chatted with people about what we chatted through? I know that you will have been careful about confidentiality, but I wondered whether you had talked with anyone about the general issues that came up? Tell me about those conversations.

I know that it was an area where we found it hard at the time to come up with what professionalism was and how we demonstrated it each day. I suppose that I have been thinking about it a lot more than other people. But I do want to talk with you about your thoughts and what it means for you.
When I ran the focus groups there were three key themes that really stood out for me that I would appreciate your thoughts on.
1 - People don't choose to be PTs, but when they take on the role it's a good one.
Is this the case from your perspective? Should it be something that people aspire to?
I heard different stories about the decision that people made to become a PT in the focus groups. What were your expectations of the role? What appealed to you about doing the job and what did you think you would be doing? (These questions are separated and not fired at the participant)
Describe the reality of the role? How did you feel about that?
How did your friends and family react when you told them you were going to be a PT?
To what extent do you think that you have inspired anyone else to become a PT?
When you were working as a PT, can you tell me about the people who you would go to for support and advice?
How do you think that you developed in the role?
Do any incidents stand out for you, times when you were unsure what to do for example?
Tell me about the impact that different people had on supporting your training and development.

Are there any people who stand out for you, people who encouraged you or helped you to take on different aspects?

2 - Sometimes it's hard to describe the difference between doing a job in a pharmacy, and being a professional PT.
How would you try to describe the difference if someone asked you to explain?
How do you show that you are a professional in your role? What makes it easier or harder for you?

Do you think that you learn what professionalism is by seeing when people are not professional? Can you think of examples of that which you may have seen during your career?

3 - PTs are trusted with personal information about patients and customers who come to the pharmacy. Being a professional means that wherever you are, whenever it is, you have to remember that you are a PT. It's who you are, not just what you do.
Do you recognise the truth in that statement. Does that mean that you will always have some kind of professional status?

Do you think that you will always have the status of being a professional?
What do you have to do to retain that status?
Have you accessed any training to help you stay professional?

What impact, if any, did you notice on the way that you worked since the focus group?

Was there anything that you thought was the main thing that came from the focus group? Was there a standout message for you at the time?

Appendix Four - Focus group participant information sheet

Exploring perspectives on professionalism for pharmacy technicians
Participant information sheet
Focus Groups

UNIVERSITY OF LEEDS

Introduction
You are being invited to take part in a focus group for a research study. Before you decide whether to take part, it is important for you to understand why the research is being carried out and what it involves for you. Please take time to read the following information carefully. Discuss it with others if you wish. If there is anything that is not clear or if you would like to receive more information, please feel free to contact the chief investigator Matthew Shaw on 07966 684529 or at edmds@leeds.ac.uk. Take time to decide whether you wish to take part, or not. Thank you for reading this information sheet.

What is this study about?
In order for pharmacy technicians to provide good quality, patient-centred care to patients they require a set of skills, attitudes and behaviours that are associated with professionalism and acting professionally. At the moment these skills are not included in the teaching programmes that pharmacy technicians complete in order to gain their qualification. Currently, not enough is understood about professionalization (the process by which people develop the competences, attitudes and behaviours of a professional) during their career and practice development.
This research seeks to address this gap and start to explore the different perceptions that pharmacy technicians have on what it means to be a professional. Exploring perspectives of professionalism will improve our understanding of how professionalism is developed and how ongoing learning programmes may support the profession in their long term learning and development.

What is the purpose of this study?
This study aims to explore perceptions of professionalism for pharmacy technicians through stimulating discussions in focus groups. This study is being undertaken for educational purposes, as part of my EdD (Doctor of Education) degree.

Why have you been chosen?
You have been chosen to take part in this study as you are a pharmacy technician, registered with the GPhC with an address in England who has shared their email address with the Centre for Pharmacy Postgraduate Education. We believe that you are working in community pharmacy and so you have the necessary knowledge, experience and practice location to contribute to this research.

What will you have to do if you take part?
If you decide to take part in this study, you will take part in a focus group of between six and eight pharmacy technicians of similar experience in practice. You will be encouraged to engage in a discussion with your fellow professionals about issues relating to professionalism and working as a pharmacy technician. You will be able to speak openly and candidly about your own thoughts and perceptions. These conversations may progress to look specifically at continuing professional development.

A facilitator will stimulate discussion and may probe for more information. The conversation will be audio-recorded. The focus group will last for 60 to 90 minutes. Drinks and light refreshments will be provided at the start of the focus group session. You will receive a £20 voucher for taking part in this focus group.

Some participants may be asked to undertake an interview following the focus group to discuss issues raised in more detail. The interview will focus on professionalism and continuing professional development. The interview will be held at a convenient location or over the telephone if necessary. It will last for approximately 30 to 60 minutes. The interview will be sound recorded.

Are there any risks or benefits to taking part?
It is hoped that participants will benefit from the process of reflection involved in the study and its relevance to their lifelong learning. There are no anticipated risks to taking part in this study.

Will information remain confidential?
Sound recordings from the focus group will be transcribed, anonymised and analysed. I will keep all information that I obtain from you strictly confidential. I will ask all participants in the focus group to agree to respect this confidentiality as well, but I can not guarantee that this will be the case.
The only exception to my guarantee of confidentiality is if there is discussion of seriously unsafe practices which have the potential to cause harm to patients, the public or staff. Should this situation arise, these issues will be raised with the individual in the first instance. After discussing the case with my supervisory team, I may have to break confidentiality and inform the relevant authority if necessary. Should this occur then I will discuss the matter with you, making it clear what is being done to address the situation.
To make sure that data about you is confidential, it will be anonymised and securely stored. Your personal details will not be used in any analysis of the data. Any personal identifiable information will be destroyed when it is no longer needed for correspondence and other anonymised research data will be destroyed approximately five years after the last publication of the anonymised research findings take place. This study will respect confidentiality of others and you will be asked not to mention patients or colleagues by name. If any of these details are mentioned, they will be removed from the transcripts of the interview data.

Do you have to take part?
No. It is up to you to decide whether to take part or not, there is no obligation on you. If you decide to take part you are still free to withdraw from the study at any time and you don't have to give a reason. It is perfectly acceptable to refuse to take part in this study or to withdraw at any time without any personal or professional detriment. I won't disclose to anyone whether you participated or not.
If you withdraw from the study once the focus group recording has been started, any comments that you make will be included. I won't be able to identify who has said what on the recording so won't be able to omit your comments even if you have withdrawn from the study.
If you take part in the focus group you don't have to take part in the interview. You can withdraw at any point.

What if there is a problem?
If you have any concerns about any aspect of this study, then you should speak with me, as the chief investigator, first. I will do my best to answer your questions or resolve your concerns. You may also wish to contact either of my two supervisors

Dr Rebecca O'Rourke
Ms Helen Bradbury

If you are still unhappy and want to complain formally, you can contact the University Research Office on 0113 343 4873. This contact is independent of the chief investigator and my supervisors.

Who has organised the study?
The study has been organised by Matthew Shaw as a student at the University of Leeds. It is likely to draw on aspects of my work for the Centre for Pharmacy Postgraduate Education, based in Manchester Pharmacy School at the University of Manchester.

Who has reviewed the study?
This study has been approved by the University of Leeds Research and Ethics Committee.

What happens next
Contact me, Matthew Shaw, the chief investigator, to let me know that you are interested in taking part in this study and to arrange to attend a focus group. I would be grateful if you could also return the completed consent form.

Contact details for more information
If you wish to ask any questions about the study before deciding to take part, please contact me:

Matthew Shaw
Centre for Pharmacy Postgraduate Education
Manchester Pharmacy School
1st floor Stopford Building
Manchester University
Oxford Road
MANCHESTER
M13 9PT
Telephone: 07966 684529
Email: edmds@leeds.ac.uk

Thank you for taking the time to read this information and for considering taking part in this study.

Appendix Five – Interview participant information sheet

Exploring perspectives on professionalism for pharmacy technicians
Participant information sheet
One to one interviews

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Introduction
You are being invited to take part in a one to one interview for a research study. Before you decide whether to take part, it is important for you to understand why the research is being carried out and what it involves for you. Please take time to read the following information carefully. Discuss it with others if you wish. If there is anything that is not clear or if you would like to receive more information, please feel free to contact the chief investigator Matthew Shaw on 07966 684529 or at edmds@leeds.ac.uk. Take time to decide whether you wish to take part, or not. Thank you for reading this information sheet.

What is this study about?
In order for pharmacy technicians to provide good quality, patient-centred care to patients they require a set of skills, attitudes and behaviours that are associated with professionalism and acting professionally. At the moment these skills are not included in the teaching programmes that pharmacy technicians complete in order to gain their qualification. Currently, not enough is understood about professionalization (the process by which people develop the competences, attitudes and behaviours of a professional) during their career and practice development.
This research seeks to address this gap and start to explore the different perceptions that pharmacy technicians have on what it means to be a professional. Exploring perspectives of professionalism will improve our understanding of how professionalism is developed and how ongoing learning programmes may support the profession in their long term learning and development.

What is the purpose of this study?
This study aims to explore perceptions of professionalism for pharmacy technicians through a one to one interview. This study is being undertaken for educational purposes, as part of my EdD (Doctor of Education) degree.

Why have you been chosen?
You have been chosen to take part in this study as you are a pharmacy technician, registered with the GPhC with an address in England who has shared their email address with the Centre for Pharmacy Postgraduate Education. You may have already participated in a focus group on this topic. We believe that you are working in community pharmacy and so you have the necessary knowledge, experience and practice location to contribute to this research.

What will you have to do if you take part?
If you decide to take part in this study, you will take part in a one to one interview with the researcher. You will be asked a series of questions and encouraged to offer your thoughts on issues relating to professionalism, working as a pharmacy technician and continuing professional development. You are free to speak openly and candidly in response to these questions.

I will probe for more information and try to stimulate your thinking. The interview will be audio-recorded. The interview will last for about 30 minutes with a maximum time of 60 minutes. Depending on your time, availability and preference, the interview may be done face to face, by telephone or by a web conference programme such as Skype™. You will receive a £20 voucher for taking part in this interview. If you have to travel then you will be reimbursed your travel expenses.

The interview will be audio-recorded.

Are there any risks or benefits to taking part?
It is hoped that participants will benefit from the process of reflection involved in the study and its relevance to their lifelong learning. There are no anticipated risks to taking part in this study.

Will information remain confidential?
Sound recordings from the interview will be transcribed, anonymised and analysed. I will keep all information that I obtain from you strictly confidential. The only exception to my guarantee of confidentiality is if you tell me about seriously unsafe practices which have the potential to cause harm to patients, the public or staff. Should this situation arise, I will raise it with you in the first instance. After discussing the case with my supervisory team, I may have to break confidentiality and inform the relevant authority if necessary. Should this occur then I will discuss the matter with you, making it clear what is being done to address the situation.
To make sure that data about you is confidential, it will be anonymised and securely stored. Your personal details will not be used in any analysis of the data. Any personal identifiable information will be destroyed when it is no longer needed for correspondence and other anonymised research data will be destroyed approximately five years after the last publication of the anonymised research findings take place. This study will respect confidentiality of others and you will be asked not to mention patients or colleagues by name. If any of these details are mentioned, they will be removed from the transcripts of the interview data.

Do you have to take part?
No. It is up to you to decide whether to take part or not. There is no obligation on you to participate. If you decide to take part you are still free to withdraw from the study at any time and you don't have to give a reason. It is perfectly acceptable to refuse to take part in this study or to withdraw at any time without any personal or professional detriment. I won't disclose to anyone whether you participated or not.
If you withdraw from the study once the interview recording has been started, then I will stop the recording and delete it. If you withdraw after the recordings have been transcribed and anonymised, I won't be able to identify who has said what so won't be able to omit your comments even if you have withdrawn from the study.

What if there is a problem?
If you have any concerns about any aspect of this study, then you should speak with me, as the chief investigator, first. I will do my best to answer your questions or resolve your concerns. You may also wish to contact either of my two supervisors

Dr Rebecca O'Rourke
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If you are still unhappy and want to complain formally, you can contact the University Research Office on 0113 343 4873. This contact is independent of the chief investigator and his supervisors.

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Who has reviewed the study?
This study has been approved by the University of Leeds Research and Ethics Committee.

What happens next
Contact me, Matthew Shaw, the chief investigator, to let me know that you are interested in taking part in this study and to arrange to attend an interview. I would be grateful if you could also return the completed consent form.

Contact details for more information
If you wish to ask any questions about the study before deciding to take part, please contact me:

Matthew Shaw
Centre for Pharmacy Postgraduate Education
Manchester Pharmacy School
1st floor Stopford Building
Manchester University
Oxford Road
MANCHESTER
M13 9PT
Telephone: 07966 684529
Email: edmds@leeds.ac.uk

Thank you for taking the time to read this information and for considering taking part in this study.

Appendix Six – Example: thematic and conceptual text analysis

Text	Category	Node
…one of the first prescriptions that I had was for methotrexate, which is only taken weekly, and it's very strict, is methotrexate. And this GP had put, on the prescription - three daily. So I queried it straightaway. I spoke to the receptionist - that's what's on the screen - sorry, no, I'm not checking this until I've spoken to the GP. Well that's what it is. So I just continued to press her - look, this needs pressing with the GP, otherwise patient doesn't get it, end of, no arguments. Two hours later, the GP was, have you got that prescription, you've not dispensed it, have you, and I was like, no it's still here - thank god for that. Because that could have killed a patient. And it's having that level of knowledge that you know that you're the one that is acting on behalf of the pharmacist. They're trusting you, because if we do something wrong, it reflects on them, and they're the responsible pharmacist, or they could be the superintendent pharmacist. It could have serious repercussions for the patient, and their families. So, there is an awful lot of responsibility that goes with being a technician. And I think it is misunderstood.	Pride Self-worth Confidence Responsibility	Demonstrates self confidence Specific knowledge – when to check and confirm Self-worth Pride in role and ability. Essential role in patient safety Making an impact/Having a purpose
I have to say, if a doctor rings me sometimes… and I shouldn't panic for the amount of times, but I don't know, I tend to listen a bit more.	Respect for professions Hierarchy of role	Perceptions of professionalism
You can be professional in anything you do. I teach roller skating. I'm professional in what I do with my coaching head on, making sure that they children I'm teaching haven't got any learning difficulties that I may not	Demonstrating professionalism in practice	High standards. Separation between a profession and being professional.

be able to see and things like that. So being professional.		

Appendix Seven – Example: coding and theming progression (focus groups)

Categories	Nodes identified	Organising themes	Global themes
Job Choice Career	Just needed to find a job Wanted something flexible Wanted something local Recommended to me by manager Suggested at Job centre No awareness at school No awareness with friends, family, environment	Lack of choice Lack of planning Lack of awareness	Routes into becoming a PT
Qualification Tutors Mentors Role models CPD Learning at work	Little link between BTech and the job Learn from colleagues Good managers make a big difference Learn from colleagues Learn from others	Drive to keep learning Expectations and responsibility Qualification doesn't enable the role	Learning to be a PT
Matriarch Old school pharmacist Bad practice	Behaviours often learned from a respected elder Role changes, but positive attitudes are maintained Recognition of poor practice as a learning tool Confidence to act in particular ways	Benefits of being explicit Trust and mentoring Inherent knowledge of right and wrong	Impact of role models
Pressure Fear Burden Struggle Box ticking	Regulation seen as judging authority Invasive in all aspects of life Adds difficulties to the workplace and practice Learning to complete a record not to do job	Need to retain registered status CPD different to ongoing learning	Impact of regulation
Quality Good practice Positive Respect Responsibility Personal Attitude Behaviours	Professionalism is a marker of high quality, but not the same thing Covers many aspects of life and attitudes are not linked to professions It is personal, not location related Need for positive behaviours and community spirit	Behaviours of a professional Esteem and respect Enduring status outside of work Seen as positive	What is professionalism