A prescription for better general practice

This special issue of our regular newsletter Commissioning Excellence celebrates the first year of the clinical pharmacists in general practice programme.

In the GP Forward View, published in April 2016, NHS England acknowledged the pressures on general practice and promised to act. One of the biggest pressures is on time as a depleted workforce struggles to cope with rising demand.

Making time in practice, the title of a report quoted by Simon Stevens in the foreword to his new deal for general practice, has become a mantra. With no immediate prospect of filling the shortfall of 5000 GPs, the GP Forward View sensibly focused on what else could be done.

More than a year after the new deal was unveiled, there have been grumbles that not enough help has reached the front-line. That may be true in some areas, but the case studies presented here suggest that the programme to bring 1500 clinical pharmacists into general practice in the NHS in England is already making a very valuable contribution only 12 months after it began in earnest.

Thirty-six PCC facilitators provided team development support to 590 practices to help embed the pharmacists in their new roles. We worked alongside the clinical training provider, the Centre for Pharmacy Postgraduate Education.

That gives us a vested interest in declaring the programme a success – but don’t take it from us: read the following pages and judge for yourself.

There is strong evidence that clinical pharmacists are already meeting their headline goal and making time in practice. In Greenford, Yaksheeta Dave reports that her work relieving doctors of tasks including repeat prescribing and medicines use reviews is saving around two hours a day for each of the four GPs at Hillview Surgery (see pages 4 and 5). You’ll find other impressive examples in these pages.

But as our headline suggests, there’s more to the story than that. Focusing too much on savings in GP workload – however valuable – obscures the other potential benefits brought by these new members of the practice team.

The Sunderland GP Alliance has modelled the savings achieved by the six pharmacists it employs across 12 practices. They amount to £700,000 – and that figure excludes savings to the prescribing budget. Their story goes on to describe 3,500 clinical interventions by pharmacists over a single quarter, and 2600 discharge or outpatient letters reviewed over a nine-month period.

Sunderland’s pharmacists stopped unnecessarily medications for 166 patients in the same period and prescribed additional medications that reduced health risks for a further 50 patients, providing important clues to where the real value of the programme lies in the long term (see page 6).

Practices are coming to realise that while clinical pharmacists perform a valuable role in supporting increasingly pressurised practice teams, that they also bring a range of different and complementary skills to the party.

It would be misleading to claim that it has all been plain sailing. Not all the practices or pharmacists who started with the programme have stayed the course, training requirements were underestimated in some areas, as were the difficulties of communicating the purpose of the new role to staff and patients, and working part-time or for more than one practice has proved challenging for some of the pharmacists.

But there is no doubting the enthusiasm of the pharmacists and practices featured here. Their stories suggest that collaborative working and a more imaginative approach to the workforce offer more than a placebo to struggling practices.

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Helen Kilminster was no stranger to general practice when she took up her role with the Whiteacres Medical Centre in Malvern, south Worcestershire.

Before the pilot programme started, she had worked in local practices for the GP federation, Stay Well Healthcare, supporting practices to deliver the CCG’s medicines optimisation service. In her varied clinics she helps patients with long-term medicines management issues, with most of those she sees having chronic conditions. Kilminster also sees some patients for acute conditions – such as colds and rashes – and those recently discharged from hospital.

“Using my advanced clinical practice skills, I am able to conduct a basic holistic health assessment of the patient and refer on to the duty doctor for any grey areas or to confirm next steps for management of patients,” she explains.

While she suspects that it will be difficult to provide evidence for her direct impact on GP workload, Kilminster says that the partners are now finishing their working day on time and the appointment book is more manageable as the high-pressure additional appointment slots are not being filled.

“I’m not sure if I’m able to make a dent in the GP workload for appointments, being here only three days a week, but patient access to appointments is good and the general feel on pressure for GP appointments has improved,” she says.

Kilminster is involved in delivering the local improvement schemes – including an initiative for improving the care of the frail elderly – and has helped increase the number of NHS Health Checks completed by the practice. She also supports proactive care of patients at risk of type 2 diabetes.

“In my care navigator role I am able to help some patients over the telephone and I see some carers or patients in the clinic. Signposting is a positive action and reception are brilliant at getting patients or carers to me. I think that community pharmacy has always had that signposting role. We know about the services and support available locally.”

Pharmacists, Kilminster insists, clearly have a unique skillset that means they can interpret data and provide effective clinical care as well as completing the routine prescription-related work.

However, she suggests that communications challenges could be the greatest barrier to expanding the programme.

“Some pharmacists need support and guidance on the softer skills – like effective communications and leadership. Perhaps understandably, pharmacists may not always know what to say and how to integrate themselves in to general practice. Practice managers don’t always know what to do with us and GPs don’t have the time. Pharmacists do need to understand the GP business and show how we add value by tying our work in with local improvement schemes that could provide new workstreams without much GP input.”

She does feel a need to prove herself, despite already having that relationship with the practice.

“We did have a new practice manager a few months after starting in this role so I did feel I was starting from scratch in terms of proving both that I am someone that can be trusted and that I was worth keeping in the practice.”

Kilminster is not the only pharmacist interviewed by PCC to voice frustration at the unanticipated difficulty of finding adequate indemnity cover for the expanded role she and the practice had planned.

“If there was a surprise or challenge it was finding the indemnity insurance and agreement on what is deemed safe for you to do. That is a huge grey area with variation across the country.”
A convincing case for change in Wiltshire

Shadia Jenner’s role has expanded rapidly in her two years as clinical pharmacist at the Barcroft surgery in Wiltshire.

Having started working with the practice on a temporary contract in May 2015, Jenner was ideally placed to be on the first training course in the NHS England pilot programme nearly a year later.

Barcroft was among a number of practices where Jenner had conducted prescribing audits on a sessional basis while working as a community pharmacist at major chains such as Boots and Lloyds.

The additional training and structure provided by the NHS England programme has helped expand her role.

Jenner explains: “Initially I was just doing prescription requests but the scope has widened significantly. I’ve been putting protocols and systems in place to help the reception team recognise what queries or requests I could handle and which need to go to the GPs.”

Convincing everyone of the need for such a new approach and systems has been a challenge, Jenner acknowledges.

“No one protocol is going to cover every situation when you are dealing with real people but we’re in a better situation for handling most requests.”

As part of her safety audit work she runs safety searches on the practice computer system and contacts patients on certain medications who have not had blood tests for more than 12 months.

Armed with her recently-acquired independent prescribing qualification, Jenner is planning to start a clinic for patients with uncontrolled hypertension in the autumn but she sees her work veering more towards ‘de-prescribing’ rather than seeing specific groups of patients.

“To be successful in this role you have to be willing to adapt to the needs of the practice because each practice needs something different.”

Having worked closely with reception staff to transform the handling of prescription queries, last autumn she put them at the heart of a drive to increase the uptake of the flu vaccine.

“The practice had not reached the targets for several years so I started a competition with reception staff to see who could sign up the most patients for the jab. I bought a few small prizes and it was a bit of fun.”

Jenner also created a safety audit tool that identifies patients over 75 who are on medications that can cause gastric bleed. This followed a case where an older person had a four day hospital stay because of aspirin-related gastric bleeding.
Pharmacist saves a GP a day

While working as a CCG pharmacist brought its own rewards, Yaksheeta Dave realised she missed the direct contact with patients she previously had as a community and hospital pharmacist.

“After several years as a CCG pharmacist I realised that although I was overseeing 26 GP practices for the CCG, I had almost no direct patient contact. I took the step of giving up my job at the CCG and undertook the independent prescribing course – and it’s certainly a decision that I haven’t regretted.”

When the NHS England clinical pharmacist in general practice pilot began in April 2016, Dave was already working as a GP pharmacist at two practices as part of a pilot organised by the practices themselves. One of those was Hillview Surgery, where she is now the full time clinical pharmacist.

Dave explains: “I knew Hillview through my CCG work and I had a good working relationship with them. A GP partner here was my designated medical practitioner for the independent prescribing course and I used to often sit in the practice reception seeing how things worked. This helped me to think about processes and how I could use my skills and knowledge most effectively.”

Her typical four day week includes:
- Telephone consultations with patients
- Liaising with community pharmacies and the surgery reception team
- Dealing with prescription queries
- Reconciling medication changes set out in discharge letters or outpatient clinic letters
- Face-to-face clinics for patients with long term conditions.

Clear and regular communication with local community pharmacies has been a priority and she says they work closely together to improve medicines optimisation – particularly for patients with multi-morbidity and those recently discharged from hospital.

Appropriate telephone consultations with patients are added to Dave’s list rather than that of the GP undertaking calls on a given day. She is also responsible for contacting certain patients whose blood test results have prescribing implications – such as those with a vitamin deficiency.

Within a few months of starting in the role, Dave says, one partner suggested she was reducing each of the four GPs’ workload by around an hour a day. Given the innovations introduced since, the practice suspects that figure may now be closer to two hours.

The impact on patients is anticipated to be similarly positive.

“The NHS England patient survey will help to provide quantitative data around patient satisfaction but I don’t think I’ve had any issues with the patients at all. Anecdotally, the feedback is 100% positive. I’m also a member of the patient participation group (PPG) and we regularly run themed coffee mornings at the practice. I recently organised an antibiotic awareness day with our PPG aimed at educating patients on the appropriate use of antibiotics.”

With her strong ties to the CCG, Yaksheeta leads for the practice on prescribing audits and incentive schemes, as well as promoting the CCG’s guidelines on issues such as antibiotic prescribing. She also drafts practice policies, a recent example being a policy for the management of MHRA drug safety updates from the Medicines and Healthcare products Regulatory Agency.
That CCG experience has also given her a good grasp of developments in the local health economy. “It’s important to be aware of what’s happening with the likes of STPs (sustainability and transformation partnerships) and local enhanced services. I like to find out what’s going on across the practice as well and attend all the staff and practice meetings. It’s good to understand things from the bottom up and the partners are receptive to my suggestions and comments.”

Even as Dave’s role continues to evolve, teamwork is the name of the game.

Senior practice nurse and clinical manager Kate Steeghs says: “From a nursing point of view and as clinical manager it is great to work together with Yaksheeta to improve patient care. It’s a bonus for the nursing team to have someone to discuss medication with and quite often we each have a learning experience together.

“Yaksheeta feeds back from her study days and she often informs us about changes in guidelines. We’ve done a lot of work together on implementing changes to the management of patient care in line with national guidance. She will also slot patients in to see one of our healthcare assistants for things like blood pressure checks or to have their weight taken.

“It’s helping us to be a team rather than working in silos.”

That applies also to the reception staff. PCC has played a facilitating role as part of the NHS England programme. Dave says that this input was particularly important in a session with receptionists that helped improve their understanding of her role and wider prescribing issues.

With Dave soon to trial the triaging of acute patients, she says that such innovations provide an opportunity for reception staff to deploy their enhanced understanding of prescribing issues.

“Obviously if I am working with acute patients on certain days then I’ll have less time to be dealing with prescription queries. I want to up-skill the current staff to deal with certain prescription queries.”

If her work triaging patients goes well the practice could reduce the use of locum GPs.

Dave sees frequent contact with patients as a vital part of the practice pharmacist’s role, but warns that it may not be for everybody.

“That does come with experience but it also depends on your personality. There are lots of things that make up a consultation and there is a lot of training on patient consultations through the programme, but if you are not the sort of pharmacist who relishes patient contact then maybe you should think carefully about whether the role would suit you.

“I’ve also got the certificate and diploma in pharmacy practice which are general qualifications and in this role we are generalists. However, I do think that my experience in community and hospital pharmacy and also as a CCG pharmacist have really helped me in my current role.”

Her typical four day week includes:

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“**It’s helping us to be a team rather than working in silos.**”

Yaksheeta Dave

Clinical Pharmacists
Sunderland’s approach to the piloting of clinical pharmacy in practice puts the emphasis on teamwork, mutual support and looking to the long term.

Megan Blythe, senior clinical pharmacist with Sunderland GP Alliance and one of those working in a practice as part of the pilot, says that the federation’s overarching role could provide a model for others to follow.

The local arrangement provides Blythe with nearly 17 hours of non-clinical time each week to support the other six clinical pharmacists working across 12 practices in the pilot.

This support includes:

- One-to-one mentoring with pharmacists
- Pharmacists shadowing Blythe in face-to-face clinics
- Quarterly clinical supervision sessions, team meetings and practice engagement sessions
- Additional clinical and system training to that delivered as part of the NHS England programme through the Centre for Pharmacy Postgraduate Education – including bloods interpretation and reading prescribing data
- A newsletter for practices.

Blythe has also encouraged the pharmacists – who each work part-time at one or two practices – to take part in multi-disciplinary team meetings and joint working with colleagues, such as home visits with community matrons.

“We work very much as a team and we’ve engaged some organisational development support to help us bond as a team. You can feel isolated at times so it’s good that we contact each other as we each have different areas of expertise.”

With just two of the pharmacists having previously worked in primary care, Blythe sees the extensive additional support the federation is providing as crucial.

Speaking about the pilot programme, she says: “Obviously we all attended the CPPE residential introductory course but some of the pharmacists came away with an idealistic view of what they would be doing in any practice. The mentoring work is about managing expectations from the point of view of both the pharmacists and the practices.

“We were shaping the practices’ view on what pharmacists could do while helping the pharmacists understand that the long-term goal is employment by the practice. “For example, the team came back with idealistic ideas around running clinics. Practices do not want to pay pharmacists to do blood pressure checks that health care assistants could be doing.

“They needed some understanding of the financial aspects and the return on investment for the practices as they start to fund more and more of the cost.

“We’ve had two practices leave which is really disappointing. They had both previously employed pharmacists for more time than was available in the pilot, and I think the difference between the pharmacists involved in the pilot at the beginning of the learning curve has been different to what they had previously experienced. There was an element of investment in their development which the practices had not previously had to consider.”

This relentless focus on the best use of the pharmacists’ skills means that the pharmacists are typically dealing with medicine queries, medicine use reviews, hospital discharge and outpatient letters and home visits.

Blythe says: “With the likes of medication reviews it might take a pharmacist longer than a GP but they are picking up quite a few things so we are improving patient safety and we link into safety event reporting.”

The pharmacists supply their activity data to Blythe on a quarterly basis with a view to establishing the benefit of the role – particularly by expressing the

“...we work very much as a team and we’ve engaged some organisational development support to help us bond as a team. You can feel isolated at times so it’s good that we contact each other as we each have different areas of expertise.”
Impact in terms of time saved for GPs.

In the first quarter of 2017 the pharmacists were involved in nearly 3,500 clinical interventions. In the nine months from July 2016 they reviewed more than 2,600 discharge or outpatient letters, added medication to reduce risk for 50 patients (such as anti-platelets for stroke patients) and stopped unnecessary medication for 166 patients.

The federation, using a model for estimating the resulting cost savings to the NHS system of such interventions, puts those savings for the first three months of 2017 at close to £700,000. That figure does not include savings in the prescribing budget.

Despite losing two practices early, the feedback is overwhelmingly positive with most wanting more of the pharmacists’ time – an aspiration the practices are willing to pay to achieve.

“That is our next challenge. Some of the practices would like the pharmacist full-time but for the pharmacist working in two practices means they can take the best from each one as each practice is different.”

Making an impact on Abbotswood

Adapting its skill-mix was very much on the radar of the Abbotswood Medical Centre in Pershore, Worcestershire 18 months ago.

The practice saw it as a route to improve access and relieve pressure on GPs.

Against that background, says practice manager Helen Perry, NHS England’s clinical pharmacists in general practice initiative “seemed to be the right programme at the right time”.

Perry says the pharmacist they recruited through the programme is a confident and personable professional whose work has improved patient care and reduced the burden on GPs.

Perry and the six GP partners and one salaried GP value the input the pharmacist is making.

“She is making a difference and we can see the potential for expanding the role: she is a very committed professional who is suggesting things she could be doing. She comes to GPs with ideas and her work is having an impact. Previously we only had the clinical commissioning group providing a pharmacist to come in and do a specific piece of work.”

Soon after the clinical pharmacist began work last April the practice undertook a major training exercise with its reception team to improve the signposting of patients to the appropriate health professional.

Perry explains: “We had a huge education and training exercise with the reception team and the clinical pharmacist was very much involved in that. This was aimed at improving the signposting of patients and coincided with us recruiting two advanced nurse practitioners over the last two years. We wanted the reception team to confidently direct calls from patients to professionals other than GPs where that was appropriate.

“Appointment pressure has fallen and patients are being seen appropriately and more quickly.”

The pharmacist runs her own hypertension clinics and Perry says patients are responding well to the pharmacist’s expertise, Perry says.

“They are coming into the clinics without any problems although we haven’t done a patient survey yet. The pharmacist is very personable and she has had real successes with a few patients we we have had with non-compliance issues.”

Patients have responded positively to the pharmacist’s expertise, Perry says.

“Appointment pressure has fallen and patients are being seen appropriately and more quickly.”

The pharmacist runs her own hypertension clinics and Perry says patients are responding well to these.

“Initially GPs referred patients to the hypertension clinic but now all new cases of patients with hypertension are directed to the pharmacist who manages their care.”
In November 2015, North Staffordshire GP Federation was successful in its bid to take part in the pilot programme for clinical pharmacists in general practice. Lucy Minshull, who provides management support for the federation describes the progress made over the following year.

The federation was instrumental in liaising with its member practices to invite any interested practice to submit an expression of interest. Each practice presented a rationale for inclusion in the pilot. All the expressions of interest clearly demonstrated the considerable pressures on practices as well as their understanding of the value a clinical pharmacist could bring.

Ten practices covering a registered population of 86,123 initially expressed an interest to be part of the pilot. The federation was instrumental in the recruitment process in both stage 1 (advertising and shortlisting) and stage 2 (interview and selection) with representation from the federation in terms of a director (Dr Medhat Guindy) and manager (Lucy Minshull), a practice manager (Alan Buckley, Norfolk Street) and practice pharmacist (Jayne Capper, Belgrave Medical Centre).

The first practices got pharmacists in post in February 2016 with others joining over the course of the next several months. Of the original ten practices a few withdrew for various reasons, including securing a GP or other clinical support, doubts about whether they could provide the necessary support to the pharmacist, or failure to agree contractual terms with the pharmacist. Two further practices joined the pilot mid-way through the year.

### Feedback on the pharmacy pilot

1. **Scope of clinical pharmacists’ role**
   - Management of discharge letters
   - Management of medication requests
   - Signing EPS electronically
   - Remotely reviewing medication reviews
   - Inviting patients for a face to face review
   - Bulk prescribing of certain items in the nursing and residential homes
   - Liaison with community pharmacists over complicated matters
   - Amending complicated medication from discharge letters
   - Liaison with local care homes over medication issues
   - Management of the prescribing budget
   - Reviewing practice prescribing polices
   - Assists nursing team with travel health, namely malaria prophylaxis
   - Review of QOF medication indicators and PLIS areas.

2. **Successes and success factors**
   - Alleviating the growing GP workload pressures across the board
   - Integration and core member of the practice team
   - Transformation of the minor ailment clinics run by both the clinical pharmacist and the ANP
   - Prescribing pharmacists have been able to adapt to the practice environment
   - Ability to come into practice with knowledge and experience to make an impact immediately and support the GPs

3. **What would we change or do differently next time?**
   - Appointment of a full time pharmacist (budgets permitting) knowing now the impact of a part-time pharmacist has had in general practice
   - More support to reduce the number of interested practices withdrawing
   - Streamline the recruitment process and ensure practice involvement at an earlier stage
   - Earlier information on what the pharmacist can and can’t support.

### Pilot practices

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<tr>
<td>Well Street Medical Centre</td>
<td>0.4 WTE</td>
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**Staffs GP federation counts the benefits**

**Pilot practices**

- Mayfield Surgery: 1 WTE prescribing pharmacist
- Werrington Surgery: 0.4 WTE prescribing pharmacist
- Willowbank Surgery: 0.5 WTE prescribing pharmacist
- Harley Street Medical Centre: 1 WTE non-prescribing pharmacist
- Well Street Medical Centre: 0.4 WTE non-prescribing pharmacist

**Feedback on the pharmacy pilot**

- Excellent mentorship by lead GP which provided increased support and confidence to the pharmacist
- Appointment of a senior pharmacist to provide support and mentorship with other pharmacists within the pilot
- Sharing of a pharmacist across two practices has worked very well and highlights the need if primary care is to survive, sharing of posts is needed
- Desire to take control of own development and ownership of role in practice
- Good support networks from Deborah Howard, education supervisor for the general practice pharmacist training pathway
- Good practice support and facilitation from Karen Merida at PCC
- One of our practices would be keen to be a training practice for interested candidates and would be 100% committed to having another pharmacist.
Our pilot practices have all highlighted the positive impacts of having a clinical pharmacist working in general practice, which has helped to relieve the growing GP workload. However, it is to be noted that a clinical pharmacist is not a substitute for a GP. Due to the positive impacts practices have experienced practices would consider having another pharmacist working in general practice. One of our pilot practices has expressed an interest in having a further clinical pharmacist in any future pilots and would like to be considered as a teaching practice for pharmacists.

The federation would be very keen to lead on any future pharmacy schemes to provide the support our member practices’ need to address the workforce crisis and highlight to practices the opportunity to diversify and work differently as shown by the successes of the first pilot.

Peterborough practice pharmacists prove their worth

Having appointed a clinical pharmacist before the launch of NHS England’s pilot programme, Cambridgeshire GP Dr Amrit Takhar has been buoyed by the impact and the potential for further development.

Wansford surgery has already appointed a second pharmacist – this time directly through the pilot programme.

“When we made the first appointment 18 months ago we were not sure what they would do but knew we could use their skillset to replace work currently undertaken by GPs. One measure of the success of this is that I now leave the practice at 6.30pm rather than 7.30pm knowing that all the day’s medication queries have been handled properly and appropriately.”

Both the clinical pharmacists are attending university and taking part in other training through the NHS the NHS England programme to become independent prescribers.

Takhar says: “We saw that we needed a second pharmacist – not least to provide cover as we really noticed when the pharmacist wasn’t there. We believed in clinical pharmacy in the GP practice anyway before the NHS England programme started.

“They have certainly reduced GP workload and that is how we will fund them. Their biggest impact has been through reconciling medicines of patients who have been discharged from hospital or whose medications have been changed by a consultant after an outpatient appointment. They deal with around 50 such hospital letters per day. The pharmacists contact the patient proactively which makes the patients feel better and helps them get to know the pharmacists so they can contact them about medicines rather than their GP.”

Although the senior clinical pharmacist only works 0.6 of a week, in a typical month he and his pharmacy colleague conduct around 200 telephone or face-to-face consultations and perform around 20 complex medicine use reviews.

Like other practices, the Wansford Surgery near Peterborough receives daily medication queries from community pharmacists, nursing homes and patients. Most of these, Takhar says, are now dealt with by the clinical pharmacists.

The practice, which has ambitious development plans including establishing a second practice with sheltered and extra care housing on-site, also has a contract to provide GP time to a 105 bed nursing home for people with severe brain injuries. Takhar says the pharmacists have come into their own in supporting the nursing home staff – issuing an average of ten items per month for each of the patients.

“These patients have very complex needs with many on PEG feeds. Although we are contracted to provide GP care on site, as GPs we used to spend another ten hours a week dealing with daily calls about medication. The patients have around 950 prescriptions per month. The pharmacists have effectively removed that time from our workload by proactively calling the home each day.”

Two of the practice’s six GPs are mentoring the pharmacists as they develop the skills and knowledge they need for independent prescribing. In time, Takhar says, they will run their own clinics under supervision, with pharmacist-led hypertension and diabetes clinics already being developed.

Takhar says: “GPs see clinical pharmacists as an expensive employee but GPs are even more expensive so it is obviously a practical approach as long as they are not doing things that other staff could do. We plan to build some surplus capacity then we could look at making our pharmacists available to other practices.”

For Takhar, it is important that the pharmacists are supported by the right structure and culture within a practice.

“We try to create a culture around development and we have a particular approach that maybe others don’t have. It’s not just about developing the practice leadership but all the team. We look to embed professionals – such as a mental health nurse – in primary care where the public can access them because they have different skillsets to the GPs. That culture means the pharmacists have fitted in well to the team.”

They will also be involved in a clinical trial for a new psoriasis treatment that the practice is participating in.

He says that PCC facilitator Janice Steed has played a valuable role in helping the practice and the professionals involved define the role and the most appropriate functions.
Word is spreading across Norfolk of the impact clinical pharmacists are having in GP practices.

When John Higgins began work as senior clinical pharmacist at the Norwich Practices Health Centre in Norwich in March 2016 he assumed supervisory responsibilities for two colleagues at neighbouring practices. They have recently secured independent prescriber status but up to seven more of the 23 practices in Norwich Clinical Commissioning Group are now seeking funding to join the NHS England pilot programme. He expects to be involved in the development of some of those pharmacists.

Higgins, who became an independent prescriber around five years ago, has had a varied career in community pharmacy and as head of pharmacy for Norfolk prisons. He feels his latest role will be for the long-term. “It’s a very interesting and varied role that gives you plenty of contact with patients and means you can make a difference to the care of people with long term conditions in particular.”

Having had a long-standing interest in chronic conditions, Higgins has completed courses in diabetes and chronic obstructive pulmonary disease over the last 14 months – as well as the mandatory training and courses in fields such as leadership skills demanded by the NHS England programme.

Now a typical day for Higgins begins with reviewing the medicines requirements for a local 200 bed nursing home. “The home includes a dementia unit and with the frail elderly their meds chop and change and there is always scope for error. I usually spend about an hour on that first thing in the morning.”

All medicines queries from patients and pharmacies are now initially directed towards Higgins, who resolves around 85% of them and refers the remainder to the duty GP. He has ten minute slots for calls to patients compared to the five minutes allocated for a GP call.

Higgins also reviews the medicines changes outlined in hospital discharge letters and contacts newly-discharged patients. “Often patients will have a lot of new medications so we see if they have any queries and they welcome that.”

Another piece of proactive work Higgins has initiated is inviting people on ten or more medications for a half hour consultation. “We know our hospitals are very full and people with ten or more medications are three times more likely to be admitted to hospital. They are delighted to come in when you offer a half hour appointment. Patients leave with a greater understanding of their medication and where appropriate I can increase medicine optimisation and address any worries.”

He also typically has eight 15 to 30 minute face-to-face appointments with patients each day – mostly people with long term conditions. “GPs in the practice have reported a significant increase in their daily workload when I’m not present at the practice,” Higgins says.

The GPs are also able to see more patients each day as a result of the clinical pharmacist dealing with so many of the prescription queries.

Working full-time at just one practice and being an independent prescriber are both advantages in his new role, Higgins believes. “Being an independent prescriber has the benefit that I don’t need to interrupt the GPs to sign my prescriptions when I have seen the patients. I know that some pharmacists are working across two or more practices but being fulltime at one helps you embed into the team and you can take care of any queries from colleagues quickly.”

That has also helped Higgins’ new colleagues understand his role and the skills and expertise he brings to the practice. “There is a bit of an education role in terms of making colleagues aware of your skills and expertise. Their only contact with pharmacists previously was often a brief telephone call to sort out a query. Some staff felt threatened and were not sure exactly what I would be doing and you need to show the GPs that they can be confident about you being involved in a patient’s care.”

With his practice playing a leading role in the NHS England programme locally, Higgins is sure he is part of the future. “In five years’ time every practice will have a pharmacist. It will be just like the move to appoint practice nurses that started 25 years ago – now every practice has at least one. The pilot programme started in response to the problem in recruiting GPs and that has got worse over the last two years – as has the recruitment of practice nurses and nurse practitioners.”
As he marks his first anniversary as full-time clinical pharmacist at the Churchdown Surgery in Gloucestershire, Ziad Suleiman is confident that the role has a big future.

Suleiman was recruited as part of NHS England’s clinical pharmacists in general practice programme. He says: “In some parts of the country it is taking some time [for patients to book appointments] but word is spreading. It is essential for GPs. The pharmacist can have an impact on almost every aspect of the practice. It’s not just about prescription queries – it’s seeing patients, running clinics and training colleagues.”

Suleiman estimates that his work reduces the daily GP workload by more than 3.5 hours – and that figure excludes most of the GP appointments he saves by running his own clinics.

It takes into account his work on:
- Repeat prescription queries (90 minutes)
- Hospital discharge medication changes (35 minutes)
- Telephone appointments for medication queries from patients, pharmacies and carers (50 minutes)
- Annual medication reviews (at least 20 minutes)
- Home visits (five per month)
- Batch prescriptions (20 minutes).

GPs are now dealing with around 20 medicine-related telephone queries each day – compared to 60 before Suleiman took up his post.

With those responsibilities taking up around half his day, Suleiman is kept busy running poly-pharmacy, asthma, hypertension and anti-coagulation clinics. In his first year he saw more than 600 patients in those clinics. He is also first point of contact for pharmacies and for care homes with medication queries.

Responsibility for annual reviews of patients with rheumatoid arthritis is set to pass to Suleiman shortly.

“The GPs know that a lot of those patients are on massive amounts of medication and I obviously have the poly-pharmacy expertise.”

He has also trained the practice’s nursing team and up-skilled healthcare assistants (HCAs) and reception staff.

“Last June we had 62 asthma patients using 12 or more salbutamol inhalers a year – which puts them in the high-risk category. I did some work with the nurses and that figure had fallen to 23 by March.

“I knew the HCAs were doing a good job so I discussed with the partners the possibility of them running hypertension clinics. I developed a template for them and we did some joint clinics together and now the HCAs see 70% of the patients with hypertension and I see the rest, with any uncontrolled patients referred to me.”

Suleiman is confident that his positive experience signals that the role is sustainable across general practice. And having made his presence felt in the best possible way amongst the GPs, Suleiman says that cluster working across local practices could help provide some cover when he’s on leave.

He is keen to be part of building that future: “I wanted to be part of something that was new and from a professional point of view I really want to get pharmacists better-established in general practice.”

Positive signs for future in Gloucestershire

“When we invite patients to my clinics the letter is from myself and explains my skills and expertise so that probably helps as well.”

Suleiman is confident that his positive experience signals that the role is sustainable across general practice. And having made his presence felt in the best possible way amongst the GPs, Suleiman says that cluster working across local practices could help provide some cover when he’s on leave.

He urges practices embarking on the process to ensure that partners, staff and patients are clear about the pharmacist’s role.

“I work for a forward-thinking training practice and I was welcomed into the team immediately. We made a real effort to explain why I was here with an article in the practice newsletter and leaflets and posters in the reception area.”

Perhaps that is why he has not encountered much patient wariness at seeing a pharmacist rather than a GP.
Worcestershire practice shows how pharmacist can make a difference

Overcoming the image of the high street pharmacist packaging pills and offering over the counter remedies for a sore throat is a challenge for practices employing clinical pharmacists.

Mohammed Jivraj has had a significant positive impact since taking up the post of clinical pharmacist at the Spa Medical Practice in South Worcestershire just over a year ago.

However, business manager Joy Smith says realising the full potential of his skills and the role he fills has required education of both patients and the rest of the practice team.

“We have worked to build staff confidence in going to Mohammed for advice rather than asking a doctor. We’ve pushed that along by providing him with a clinical room in the nursing area so, for example, a nurse doing a respiratory review can use him as a sounding board.

“We had a comprehensive induction plan which saw Mohammed attending doctors’ meetings, nurse meetings and the admin team meeting so everyone understood his role and he understands how the practice works.

“We’ve also asked all staff to use the term clinical pharmacist when talking to patients. People hearing the word ‘pharmacist’ tend to think of someone behind the counter just dispensing pills. They don’t realise that many pharmacists can review conditions and prescribe medications.”

“We took time to interact and build understanding with our patient participation group so that they could help us educate fellow patients with this new clinical pharmacist role.”

Smith and the practices had been exploring the idea of appointing a clinical pharmacist for some time. They leapt at the opportunity offered by NHS England’s clinical pharmacists in general practice programme – which is being administered in south Worcestershire by the local GP federation, SW Healthcare.

One of the impediments to an earlier appointment was concern over whether the practice would provide sufficient work for a clinical pharmacist working full time.

Smith says: “We recognised the value of developing a clinical pharmacist role and the different skills they brought but, as always, we had to think about the money.”

Those financial concerns were eased with the financial support from NHS England, which is part-subsidising the employment costs. Initially the Spa practice shared Jivraj with a neighbouring practice, but he is taking up a full-time role with the Spa practice from May.

Smith recruited Jivraj with the support of SW Healthcare’s lead clinical pharmacist, Marianne Tucker-Martin, who was involved in the appointment process of all 28 clinical pharmacists in south Worcestershire to ensure they had the right clinical and consultation skills.

An independent prescriber for patients with asthma and other respiratory conditions, Jivraj’s key functions at the practice include:

• Half hour consultations each morning for patients with asthma
• Six 15 minute consultations with other patients
• Medicine optimisation audits and leading the practice’s activity around the clinical commissioning group’s local QOF requirements for asthma and chronic obstructive pulmonary disease management
• Medicines use reviews – under the supervision of the practice’s prescribing lead GP
• Responding to telephone calls from patients with enquiries about prescriptions, side-effects and whether one prescribed drug can be safely used with an over-the-counter medicine
• Highlighting drug alerts to colleagues
• Managing medicine changes following hospital discharge.

If his scheduled clinics are not fully booked, Jivraj will often look at the duty doctor’s list of call-backs to patients and telephone patients he thinks he may be able to help – further reducing the burden on GPs.

As Jivraj has a background in retail pharmacy, Smith says he has also proved a great source of knowledge for the GPs about the most cost-effective medicines.

“If Mohammed has any concerns about the best treatment for a particular patient he obviously links back in with one of the GPs but he has made himself an integral part of the clinical team with his really different skillset.”

The practices have continued to work with both Tucker-Martin and PCC’s facilitator for the pilot programme in south Worcestershire, Polly Goodwin.

Smith says of Goodwin’s role: “She has helped us focus on the need for wider engagement with staff and patients about Mohammed’s role. We needed the time out to think about those things and our sessions with Polly allowed us that. At the start she asked us what success would look like and one of the things we said was that we would have him here full-time and that it would be a permanent role. That is happening now which is great.

“All the GPs say they have felt a positive benefit in terms of reduced workload – although the level of demand from patients is such that even with the other initiatives to reduce their workload we’re not seeing a financial saving because as yet we have been able to reduce the time demand of our GPs to within their statutory working hours. We will continue to move towards this.”

Meanwhile, Tucker-Martin and Goodwin have worked with the continuing professional development supervisor to ensure clinical pharmacists in south Worcestershire receive training linked to issues identified in professional assessments – such as interpretation of biomedical results.

Tucker-Martin says: “We’ve been identifying development tools that might help one individual but will also be of benefit to the other pharmacists. We’ve worked with Polly to understand the leadership and sustainability plans for each practice.”