



SHARING A CLINICAL PHARMACIST



**A brief guide to making it work for
the pharmacists and their practices**



Sharing a clinical pharmacist

As the national rollout of NHS England's clinical pharmacists in general practice programme continues, this brief guide looks at the experiences of pharmacists and practices involved in the early stages of the scheme, with particular focus on those working for two or more practices. It is also informed by the experience of the PCC team who provided them with support.

Introduction

The clinical pharmacists programme is a tangible expression of the principle set out in the Five Year Forward View that the primary care workforce would need to develop richer multidisciplinary teams, partly because these offer benefits in their own right, partly because they provide a way to address workforce shortages and increasing workload.

Policy makers and professional bodies have long recognised that general practices need to work together to share resources and create the scale both to make them sustainable in the long term and to provide services of the range and quality that their patients expect and deserve.

The necessary scale is often described in terms of populations of between 30,000 and 50,000 but it has been left to practices themselves to decide what organisational arrangements they make to achieve it.

This guide, based on the experiences of practices sharing clinical pharmacists provides anecdotal evidence that collaboration can be based on simple, informal arrangements and does not depend on

radical structural change. It also suggests that if this can work for clinical pharmacists, then the prospects for further collaborations based on sharing other staff are also encouraging.

The guide is not a flag-waver for national policy, but a simple reflection of the experience of professionals and the organisations that have employed them. It demonstrates the potential for sharing clinical pharmacists, but is honest about the challenges involved and explains how individuals have overcome them.

We hope this will be useful for pharmacists and practices that have joined the programme recently and those who may consider employing a clinical pharmacist in future.

You may also be interested to read the introductory guide in this series (*Clinical pharmacists in general practice: A brief guide to getting started – for practice teams and clinical pharmacists*). We aim to produce others as the programme evolves.



Why most clinical pharmacists will be shared

Practices hoping to join the clinical pharmacists in general practice programme are expected to be working with a minimum population of 30,000 patients. Few practices have a registered list of this size so, by default, NHS England assumes that any practice that wants to benefit from the programme will be working with at least one other.

Another qualifying condition is that a clinical pharmacist will hold a full-time post or, where that is not possible, will be employed for at least eight sessions a week – the equivalent of 0.8 of a whole-time member of staff (0.8 wte).

NHS England expects that there will be one full-time clinical pharmacist for every 30,000 patients.

Recognising that clinical pharmacists will need mentoring and other support from more experienced colleagues, NHS England also expects the programme to have one senior clinical pharmacist for every five clinical pharmacists.

The bottom line is that most practices on the programme will be sharing clinical pharmacists for the foreseeable future.

In most cases these arrangements will see individual pharmacists shared between two or at most three practices. Any more than this and arrangements may become unworkable for the individuals and practices concerned.

Clinical pharmacists working across two or more practices may have to contend with:

- Different clinical systems and clinical protocols
- Different practice policies and processes
- Travel time between practices
- Different patient populations
- Different cultures
- Varying expectations of the clinical pharmacist's role



Tips for success

- You need to work together. Talk to the other practices you share your clinical pharmacist with – and include the individual in these discussions
- Share your practice’s vision and objectives for the clinical pharmacist’s role and look at where they align with those of the other practice – there may be potential to save time or money or both. These discussions should not just be between GPs – it is the practice managers who will be more familiar with the detail of how the practice operates on a day-to-day basis
- Try to identify a small number of common goals and priorities. You might want to get started on this before the clinical pharmacist starts work. This may mean making some compromises to come up with a workable arrangement. It also puts a premium on each of the practices and their teams having a common understanding of what the pharmacist can and can’t support
- One of the programme criteria is that clinical pharmacists will work as “part of a multidisciplinary team in a patient facing role”. When a relatively inexperienced shared clinical pharmacist first starts work, it may be helpful to work towards this requirement in smaller steps:
 - Focus more on clinical administration at first – this will allow time for the clinical to become familiar with each practice’s systems, protocols and way of working
 - For patient facing work, consider starting with areas such as hypertension (which are relatively protocol driven) to help build confidence and familiarity. It might also be useful, in the early weeks, to consider other types of patient facing work, eg arrange for the clinical pharmacist to attend meetings with members of the patient participation group (PPG) or practice self-help groups to explain the clinical pharmacist’s role.

- As the clinical pharmacist settles into the role, the work balance can be adjusted more towards patient-facing work. All clinical pharmacists are different and will progress at different rates depending on their experience, their skills and the support and supervision you provide
- Each practice needs to understand the clinical pharmacist's commitments at the other practices, as well as their training commitments. Look at:
 - Clinic times
 - Practice and multidisciplinary team meetings - try to avoid clashes with the clinical pharmacist's sessional commitments in the other practices
 - Balance of patient facing and non-patient facing work (telephone consultations are still counted as patient facing)
 - The individual's training timetable - each clinical pharmacist has 28 days of protected study time spread over 18 months regardless of whether they are full or part time. Study time for the independent prescriber's qualification is in addition to the 28 days
 - Availability of consulting rooms or clinics in each practice
- Harmonise induction arrangements. Some things may only need to be done once, such as DBS checks, meeting the community team and meeting the CCG pharmacist. Others are necessarily practice-specific
- Clinical supervision and liaison with the senior clinical pharmacist: can one GP in the group take lead responsibility for this?
- KPIs: can one practice lead on this?
- Indemnity: can one practice lead on arranging indemnity and investigate what arrangement offers the best deal? Be aware, however, that indemnity cover has to be on a per practice basis.

A real example

The table on the next page comes from a bid site with 14 practices across four localities. Each locality is sharing a full time clinical pharmacist, except the largest (locality D) which has one full-timer and a 0.9 wte senior clinical pharmacist. The latter is employed for nine sessions a week, two of which are allocated to mentorship and guidance of the four clinical pharmacists.

Note that:

- No practice has less than 0.2 wte (two sessions a week) – the smaller the number of sessions worked at a given practice, the harder things become in terms of continuity and integration with the practice team
- No clinical pharmacist works across more than three practices, except in locality C.

Senior clinical pharmacist

Besides advising the GP supervisor and bid sites, the senior clinical pharmacist is also responsible for providing mentorship and guidance to other clinical pharmacists – a minimum of one session per month each. So if a site has four clinical pharmacists, the senior clinical pharmacist will be providing at least four sessions of support to them each month in total, in addition to any clinical commitment.

Contract holder

There are various options under the current programme criteria. The clinical pharmacist may be employed by one of the sharing practices or by a GP federation, CCG or NHS trust on the practices' behalf.

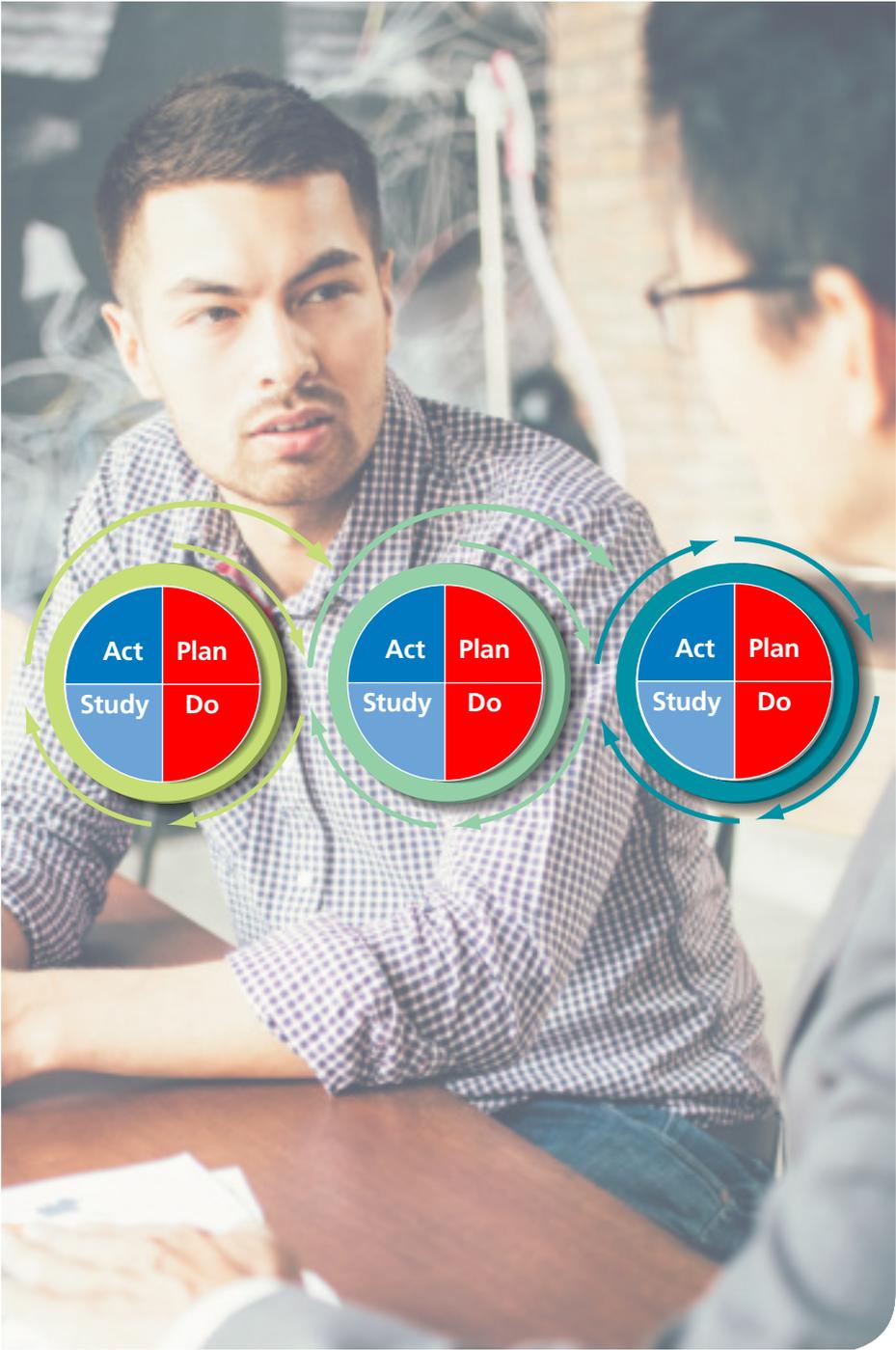
Travel

The contract holder is responsible for travel costs, for example for the clinical pharmacist to attend CPPE pathway training or travel between practices.

| Locality/practices (employing practice shown in bold) | Patient numbers | WTE | Work programme | |
|---|-----------------|-----|---|--|
| | | | Patient facing | Administrative |
| Locality A - 3 practices Agreed clinical priority areas: asthma and diabetes | | | | |
| Practice 1 | 11,100 | 0.4 | Medicine reviews, face to face clinics for patients with asthma, diabetes | Prescribing queries, hospital discharges - reconciling medication changes, QOF reviews |
| Practice 2 | 7,900 | 0.3 | | |
| Practice 3 | 9,400 | 0.3 | | |
| | 28,000 | 1 | | |
| Locality B - 2 practices | | | | |
| Practice 4 | 17,500 | 0.5 | | |
| Practice 5 | 14,000 | 0.5 | | |
| | 31,500 | 1 | | |
| Locality C - 5 practices Agreed priority area: respiratory disease | | | | |
| Practice 6 | 5,400 | 1 | Face to face clinics for patients with asthma/COPD at locality hub | Want CP to undertake ARTP accredited training to enable him to do spirometry (interpretation). Practice nurses undertake the diagnostic testing (lung function tests). Develop strategy for identifying earlier patients with or at risk of developing respiratory disease |
| Practice 7 | 8,200 | | | |
| Practice 8 | 6,250 | | | |
| Practice 9 | 8,500 | | | |
| Practice 10 | 4,900 | | | |
| | 33,250 | | | |
| Locality D - 4 practices Agreed clinical priority areas: minor ailments, care of the elderly | | | | |
| Practice 11 | 14,500 | 0.5 | Medicine reviews, telephone consultations | Hospital discharges - reconciling medication changes, QOF reviews; liaising with community pharmacies, care homes and surgery reception |
| Practice 12 | 13,400 | 0.4 | Minor ailments clinic, home and care home visits | |
| Practice 13 | 10,750 | 0.3 | Minor ailments clinic, home and care home visits | |
| Practice 14 | 17,100 | 0.5 | Medicine reviews, telephone consultations | |
| | 55,750 | 1.7 | | |
| Senior clinical pharmacist support to CPs | | 0.2 | | |
| Total wte (0.9 wte senior CP & 4wte CPs) | | 4.9 | | |
| Total pharmacists | | 5 | | |

What can go wrong (and how to avoid it)

- Sharing practices need to ensure that there is a sensible balance between the potentially conflicting demands on their clinical pharmacist's time – otherwise their motivation and job satisfaction may suffer. This is something the senior clinical pharmacist and GP supervisor may wish to keep under review
- Your clinical pharmacist is not only there to do clinical administration. If this becomes their dominant role, they won't be happy and the practice and its patients won't get the most value from them
- Each practice needs to do its bit in supporting the clinical pharmacist's role. As we heard from a participant in the first phase of the programme: "Where it went wrong in one phase 1 site was where one practice felt they released the clinical pharmacist for all the training, gave clinical support and the other practices didn't"
- Give and take is also important – for example, to help with wider clinical staff holiday cover across the group it might be helpful if the clinical pharmacist works more or less sessions at a particular practice occasionally
- Agree a step by step approach that will achieve some of each practice's goals and align the clinical pharmacist's work programme so that there is as much consistency as possible
- Remember to prioritise. The clinical pharmacist cannot be expected to learn everything at once, for example diabetes and COPD in one practice, asthma in another. Agree one clinical priority at a time, preferably one that the clinical pharmacist is already familiar with
- Take a PDSA (plan, do, study, act) approach. Continual review of processes and work plans is particularly useful when the clinical pharmacist and the wider practice team are getting used to a new role. Be prepared to change what isn't working.





Catherine Hilton

Catherine Hilton qualified in 1995, working in community pharmacy before spending 10 years in PCT and CCG roles and three years in community services and community hospital settings. She has been an independent prescriber since 2014.

She now works 2.5 days across two practices: Sid Valley, Sidmouth with a list of 16,000 patients and Townsend House, Seaton (6,000 patients) dividing her time equally between each.

"We made it work," she says.

It helped that both practices were enthusiastic about the clinical pharmacists scheme with two practice managers keen to try collaborative working.

Catherine is employed by the smaller of the practices (Townsend House), where the practice manager is her line manager, and works on secondment to the other. Two GP leads at the respective practices provide clinical supervision.

It also helps that the two practices use System One, reducing the learning curve for getting to grips with the clinical system.

Catherine likes the variety created by the difference in size between the two practices, which are reflected in the work. A hundred percent of her time is spent seeing patients at the smaller practice. At the larger one, "I spend about 70% of my time on patient-facing work and the rest on other responsibilities including complex medication related tasks, medicines safety work and reviewing and developing protocols".

Though some clinical pharmacists on the programme have taken a gradual approach to patient-facing work, preferring to learn about practice systems and processes first, Catherine was keen to see patients from the outset and make full use of her prescribing qualification.

"Do lots of patient facing work. Don't shy away from this. Start with small clinical areas such as QRISK and hypertension clinics then gradually expand areas alongside competence. It's better to see patients from the start and initially have longer appointment times as that's how you learn."

Catherine acknowledges that the amount of access the clinical pharmacist gets to patients may not be entirely their own choice.

"All GPs are different. Some will use you lots and be happy for you to completely manage their patients yourself from the start, whereas others won't use your skills at all. It may take time for them to feel their way and build up trust and confidence in your abilities before they are happy to delegate – but that's not a bad thing."

There were some challenges. Two practices meant it took longer to settle in and get used to different ways of doing things. A part-time working week divided equally between the two sites also demands good time management. "I have to make sure everything is finished as tomorrow is usually my next week. Not only do I need to be organised myself, I need to ensure that colleagues are aware of time scales for actioning certain tasks as there is no one to delegate my work to when I'm not there," Catherine says.

Being realistic about what you take on is also essential. "At the start there are lots of things you could do, but this might not be sustainable long term when you are seeing more patients. Try not to volunteer for too much at first although it is very tempting to. Oversee or implement a system then hand it over. Be realistic. Choose things that you can do or manage if you are only there one day a week."

Logistics can also be challenging. Catherine has the use of the same consulting room at Townsend House, but has to be more flexible at Sid Valley where the same consulting room isn't always available each week.

Among her advice to others is to keep management arrangements as light as possible. Her line manager is at the employing practice, though she notes the importance of "go to" people in both. "Familiarise yourself with contacts for IT, clinical advice, nurses, reception teams and so on. Spend time sitting in with all teams, so they have a chance to get to know you and what you can do."

While building these relationships will be down to the individual, the practice can help. "A really good induction is vital," Catherine says.

She says: "I feel privileged to be in this job and to be valued and respected by all members of the practice team. The practices do see me as the medicines expert and ask for my advice about lots of different things. My patient-facing work is also very varied. I manage patients with long term conditions which include diabetes, hypertension, CHD, AF, CKD and osteoporosis as well as polypharmacy medication reviews.

"Patients really like the fact they have a longer appointment time with me than the doctor and that they have the opportunity to ask lots of questions."



Sue Allred

Sue is head of clinical pharmacy at SEL GP Group and senior clinical pharmacist at Colton Mill and The Grange Medical Centre. As part of her role at SEL GP Group, she oversees and manages the clinical pharmacist team comprising two Band 8a and three Band 7 clinical pharmacists on the NHSE scheme and one Band 7 and one 8a employed through separate funding.

The biggest challenge faced by the clinical pharmacists, Sue says, was building relationships and trust with practices to allow them to do the role. This took time and became harder the more the clinical pharmacists were required to divide their time between practices.

“The more stretched clinical pharmacists are across practices, the harder it is to build these relationships. Practices also need time to understand the role,” she adds.

Sue had regular meetings with each practice to get a picture of how things were going and to troubleshoot any issues.

The collaborative approach to using clinical pharmacists had one big advantage. It meant that learning could also be shared. “We were able to identify good practice and ensure that what worked well could be adopted across all the practices in the programme,” she says.

Sue acknowledges that the different working practices they encountered at each GP practice made it difficult for the clinical pharmacists, particularly at the start. “No two practices work in quite the same way,” she says.

HER TOP TIPS FOR OTHERS FACING THIS CHALLENGE INCLUDE:

- Build relationships with your practices
- Great communications – make yourself known
- Set up a network of peers so you don’t feel isolated – use WhatsApp or similar when it’s not possible to do this face to face
- Make links with the CCG and local hospital to help you understand your local medicines economy

Taking time to understand how general practice works is particularly important for individuals new to primary care, including the roles of each member of the practice team.

Awareness of the experience of the pharmacist is just as important for the practice, which needs to understand what the individual is likely to know and adjust its expectations accordingly.

"It's vital to make sure practices have realistic expectations from the start about the role of the clinical pharmacists, their development and the likely trajectory of the CPs taking on new or additional task as they develop. Practices have to realise that they won't be able to do everything from day one."

Other local knowledge is important, from how to access blood tests to rules around local approvals, restrictions and guidelines.

"Coding activity is important – you need to agree a consistent way of doing this so that it is easier to understand activity and performance and share this with practices. We have a Read code formulary to help pharmacists be consistent with coding – this also saves time," Sue says.

With limited time available to spend with each practice and further constraints imposed by the need to travel between locations, some clinical pharmacists may be tempted to spend at least some of their time working remotely. But this may have drawbacks of its own, Sue warns.

"Remote working is possible but this makes relationship building harder," she says.



Maulik Jhaveri

Maulik Jhaveri is senior clinical pharmacist, dividing his time equally between two practices.

Marilyn Brooks is practice manager at Clifton Medical Practice and Ian Bonser is practice manager at Rivergreen Medical Centre in Nottingham.

The two practices had an existing close relationship and history of working together so they had good communication from the start. Marilyn, Ian and Maulik agree that this is the most important success factor in sharing a clinical pharmacist. "It is important to make sure you are on the same page and making decisions together," says Ian.

Marilyn identifies two things that made it easier to integrate Maulik with both practice teams. The first is having realistic expectations of the clinical pharmacist. The second is being prepared to provide the support and supervision they need while they are training.

Maulik is employed by each practice on a 0.5wte basis. Although the practices tried to anticipate administrative needs, a couple of issues around pay and conditions cropped up and needed to be resolved. "Get these differences in pay sorted first," Ian advises.

Making sure that the sharing arrangement is equitable in other ways can also take work.

Initially Maulik worked every morning in one practice and every afternoon in the other to give each practice continuity of cover. But this arrangement didn't work well for Maulik who found himself dashing between locations. It wasn't ideal for the practices either as Maulik's schedule meant he was unable to see some patients, such as working people, at one practice.

"It did take some time for his hours to become settled, they moved around a fair bit and it took negotiation," admits Marilyn.

Maulik now works a full day in each practice and a mixture of early and late half days for the rest of the week.

Maulik notes that differences between practices may impact the clinical pharmacist, such as differences in coding medication reviews or how patients are monitored. "Every practice has a different skill mix and ethos, tasks are shared differently and there are lots of people to get to know and find out what they do and how you fit in. In my case, I love that but some might find it difficult," he says.

TIPS FOR OTHER PRACTICES:

- Talk to each other. Clear communication is the most important success factor
- Agree joint expectations
- Support the clinical pharmacist, recognising it will take time for them to make a full contribution
- Agree employment issues at the outset: holidays, expenses, support and supervision
- Training and courses – agree priorities for both practices in the individual's development plan
- If the clinical pharmacist is a senior, remember they need time to support juniors. Agree how you will fit that into the week and how you will give them some admin time

Clinical pharmacists will be asked to do different tasks in each practice. Again negotiation is important to meet the aspirations of the pharmacist as well as the needs of the practice.

Maulik developed a hypertension protocol in line with NICE guidelines and while it was implemented by both practices, it was done in different ways. "When a clinical pharmacist introduces a change it is important to discuss it with the whole team so everyone knows what is involved," he says.

A key learning point for clinical pharmacists, says Maulik, is that how things are done in general practice is more nuanced than in pharmacy. GPs have individual ways of working and there is no "right" way; they will each do what they think is best in the interest of the patient.

"As a clinical pharmacist learning to work with patients across two practices this can be a challenge. You have to learn how each practice interprets the same information to make decisions, he says."

There are opportunities for shared learning across practices. For instance, Maulik developed a new system for managing safety alerts which he implemented in both practices, saving time for both practice managers. "He has set up a brilliant audit trail for safety alerts – when an alert comes in, he highlights how many patients are affected and what we have done about it," says Marilyn.

Communication and willingness to negotiate are recurring themes. Maulik says: "There may be overlap in some areas between the pharmacist and other staff, such as nurses. To avoid conflict or resistance to change, keep in regular communication with nurses and GPs, and agree with all concerned where your role fits into the patient pathway and practice processes. Some pharmacists may find it disheartening to run into areas of resistance, but if you stay put, keep smiling, keep an open mind and keep communicating, it will get better through time."



Jimmy Cheung

Jimmy Cheung is a senior clinical pharmacist working for Warrington Health Plus, a community interest company which includes all GP practices in the Warrington area (around 208,000 population and 27 practices). He has experience of both phase 1 and phase 2 of the clinical pharmacists in general practice scheme with responsibility for 18 pharmacists.

What are the advantages/drawbacks of sharing a pharmacist?

- For medium-sized practices that do not need a dedicated full-time pharmacist, employing a shared pharmacist is a good option
- Practices can share the workload involved, eg one practice can lead on HR issues, another on governance, clinical supervision or appraisal

Advice for clinical pharmacists or other health professionals in the same situation

- Don't worry about the future. If you see your career as being in general practice, working across two or three practices offers the opportunity to gain a wider breadth of experience, and at the end of the scheme you are likely to have two or three permanent job opportunities to choose from!

Tips for practices sharing a pharmacist

- You need to work together. A memorandum of understanding (MoU) can be helpful. This should set out a small number of agreed priorities, confirming the clinical pharmacist's educational/training commitments and including a broad brush job description. The MoU can be modelled on bits of the enhanced service specification
- Sharing a pharmacist works best with two or at most three practices. Anything less than two sessions a week at any one practice doesn't work as there's no opportunity for the clinical pharmacist to become part of the practice team. Remember too that the pharmacist's education/training commitment is 28 days over 18 months regardless of whether the CP is full time or part time

- CPs need to do patient facing work in order to do their jobs properly
- Indemnity – the shared job description (see above) can be used to get competitive quotes from insurance providers. It can often be cost effective to negotiate a group policy rather than for each practice to obtain individual cover. Be aware that this is a developing market, and also that the clinical pharmacist job description will need to change over time to reflect the clinical pharmacist's developing skills – so keep it under review.

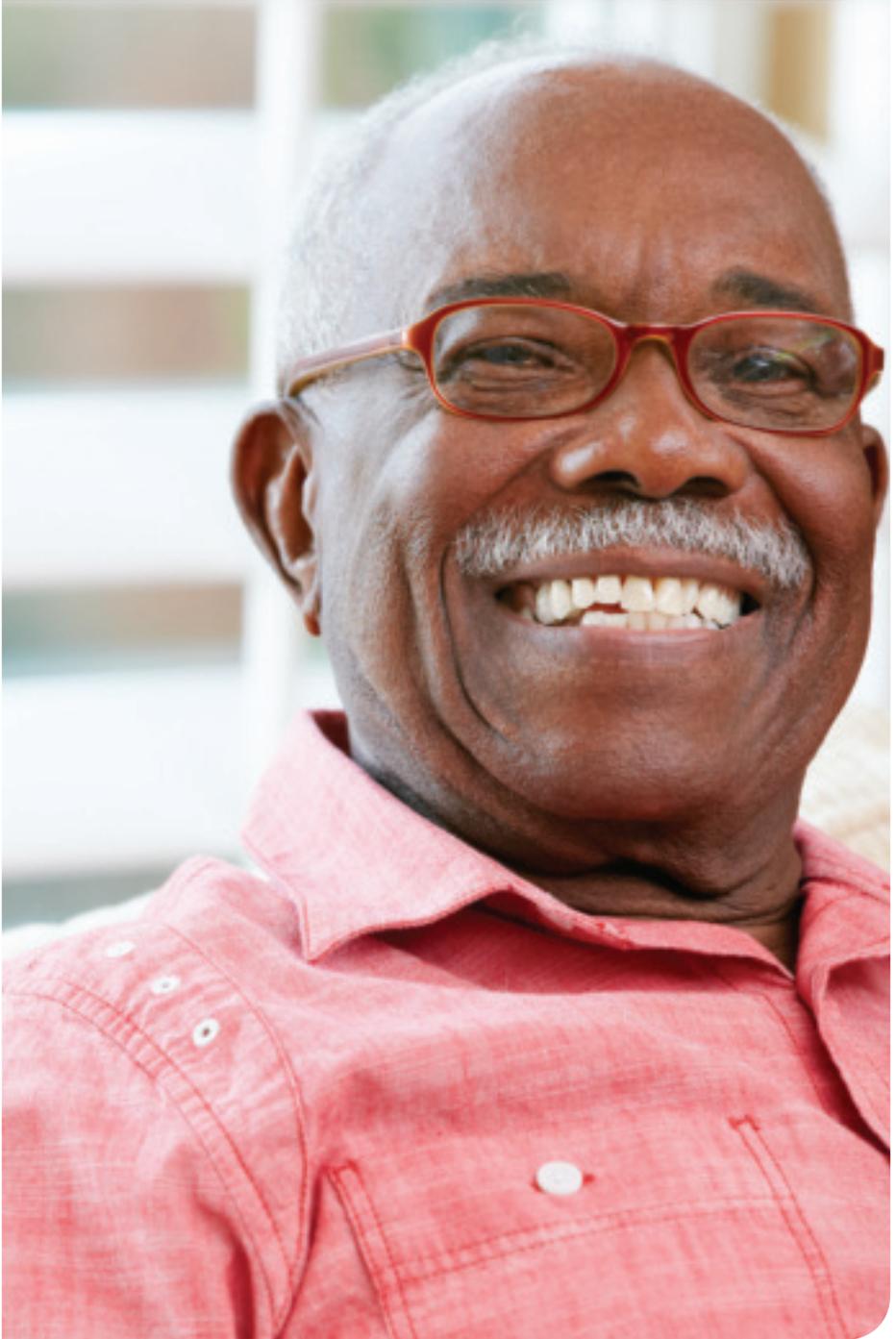
About PCC

PCC is commissioned by NHS England to deliver organisational development and has facilitators working with the site leads to support all participating practices.

PCC is providing sustainable support using a coaching approach to work with the site leads and key members of practice teams. The aim is to make the practice team more confident and better able to manage change. This is both to integrate the role of the clinical pharmacist now and to develop the skills to help manage workforce and other changes in future.

You can find out more about PCC at www.pcc-cic.org.uk/about or by sending an email to enquiries@pcc-cic.org.uk.

Further information including case studies, guidance and resources developed by practices and clinical pharmacists already taking part in the programme can be found in the Clinical Pharmacists in General Practice Team Development Support pages of www.networks.nhs.uk





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