Clinical Pharmacist Ambassador Update

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What are established clinical pharmacists doing to save GP time and optimise medicines use?

From the North School of Pharmacy and Medicines Optimisation

Clinical pharmacists are one of five reimbursable roles within the Primary Care Network Directed Enhanced Service (DES)[1]. From July 2019, every primary care network may receive recurrent funding to hire a clinical pharmacist. Over time, a network could employ a team of up to six (whole time equivalent) clinical pharmacists. Clinical pharmacists employed through the Network Contract DES will be enrolled in, have completed or be exempt from a national education pathway[2].

General Practice Pharmacist Gareth Malson in consultation with patient

The key responsibilities for clinical pharmacists working as part of a multi-disciplinary team in a patient facing role are described in the DES. Clinical pharmacists come with different levels of experience and competence and from different sectors of pharmacy practice.

We thought it would be helpful to share some ideas of what established clinical pharmacists are doing to optimise medicines use and team-based care. Here, seven clinical pharmacists offer views on the various stages of the journey they have undergone to become established clinical pharmacists working in general practices.

Case study 1: Working out where to start

When I started as a newly qualified pharmacist prescriber in general practice, I was keen to use my clinical skills but unsure of where to start. Management of hypertension was suggested by a colleague as it has clear guidelines supporting treatment and monitoring. Also, patients with hypertension require multiple appointments to titrate their medicines and achieve control.

By setting up a hypertension clinic, I grew my clinical expertise and confidence while honing my consultation skills. Since hypertension is linked to other comorbidities, I learnt to deal with COPD, asthma, several endocrine conditions and deficiency states, anaemia and minor ailments – thus increasing both my clinical skills and scope of practice.

Laura Sharp, GP clinical pharmacist, South Yorkshire

Case study 2: Developing the role to help triage patients with acute conditions

Initially my role focused on medication review and optimisation, but it quickly evolved. Whilst I was conducting reviews, patients would often ask about 'whilst I'm here' ailments. As a result, I was supported by the practice to complete a minor illness assessment and treatment course.

I now take part in the practice's telephone triage service, arranging face to face appointments with myself or another clinician, or signposting patients elsewhere as necessary. While this makes for effective use of resources, I know the GP supervisor is always available should a more complex patient present. The role has grown beyond the expectations of the practice. I am now able to identify red flag symptoms and symptoms of chronic disease exacerbation during long-term condition reviews. It enables me to deal with an eczema flare in a child presenting for

an asthma review or treat a UTI in a patient that attends for an HRT review, without interrupting a doctor or asking the patient to make another appointment.
Juliet Bell, senior clinical pharmacist, Bury

Case study 3: Working as part of the practice team

The mainstay of my role is medication reviews, either in face-to-face clinics or by telephone. I take a holistic approach; acknowledging all the patient's comorbidities which enables me to effectively prescribe and de-prescribe. This also helps patients understand why they are taking their medicines, with the aim of reducing non-adherence and medicines waste.

I run several clinics for long-term conditions. For patients with AF, a GP makes an initial diagnosis then hands over management to me. This includes starting anticoagulation, titrating rate-limiting medicines and organising the necessary follow up. For chronic diseases that already receive nursing input (e.g. diabetes and asthma), I work with nurses to optimise care for the most unstable patients. I have become accredited to initiate GLP-1 receptor agonists and insulin; so, if a patient's HbA1c is above target despite triple oral therapy, I will assess and prescribe these as necessary. For patients with asthma, a nurse will conduct the disease review then hand over to me for stepping therapy up or down.

Patient in clinical consultation with General Practice Pharmacist Katie Smolski

Deprivation levels are high and life expectancy is lower than average in my practice locality so providing care for mental health conditions makes up a large proportion of our GP workload. I conduct medication reviews for patients newly diagnosed with depression and up titrate antidepressants accordingly. I also help fulfil QOF targets relating to mental health condition management. During our 2017 CQC report, my role was highlighted as an example of outstanding practice.

Katie Smolski, senior GP clinical pharmacist, Central Lancashire

Case study 4: Reaping the benefits of repeat (batch) dispensing

In response to increasing volume of prescription requests, I initiated a sustainable system for issuing batch prescriptions in line with patients' medication review dates. Between September 2016 and July 2019, the average number of prescriptions issued by the practice each day reduced from 236 to 188. The system is now managed by the repeat prescription clerk team. (Practice list size 13,500; in July 2019, there were 2669 patients on repeat dispensing).

The time saved by repeat dispensing has been reinvested into further initiatives to improve patient safety. For example, I have developed and embedded an 'extended scope repeat prescription clerk' role which, supported by training and SOPs, includes high-risk drug monitoring (for DMARDs, DOACs and lithium) and medicines reconciliation on discharge from hospital.

Lucy Wilson, GP clinical pharmacist, Middlesbrough

Case study 5: Transitioning from a CCG pharmacist to a general practice pharmacist

After many years as a CCG pharmacist, I acknowledged that while I oversaw several GP surgeries on behalf of the CCG, I had almost no direct patient contact. I joined the NHS England clinical pharmacists in general practice project in April 2016 as a senior clinical pharmacist and never looked back. My typical four-day week now includes:

- Telephone consultations with patients (including triage of patients' acute conditions)
- Liaising with community pharmacies and the surgery reception team
- Dealing with prescription queries from patients and other healthcare staff
- Reconciling medication changes set out in discharge letters or outpatient clinic letters
- Face-to-face clinics for patients with long-term conditions (depression, pain, titration of medicines)
- Medication reviews to improve care of the frail elderly

Although pharmacists may take longer than GPs to conduct medication reviews, this often allows more medication safety issues to be identified. Reviews can be targeted at specific medication-related issues (e.g. patients with asthma using 12 or more salbutamol inhalers per year or monitoring of high-risk medicines).

Brinder Sandhu, GP clinical pharmacist, Yorkshire

Case study 6: Focusing on medication safety

I am a lead practice pharmacist within the 'Neighbourhood Integrated Practice Pharmacist in Salford Team'. One of the role's main aims is to ensure that a patient's medication is appropriate, safe and effective at any point in their healthcare journey, with a focus on preventing medication safety issues at the interface between primary and secondary care. Our core functions are:

- Face to face medication review
- Medicines reconciliation on discharge from hospital
- Implementing systems within practices to ensure high-risk medicine monitoring is done effectively
- Monitoring and managing any errors identified by the Salford medication safety dashboard
- Education and training for practice staff on medication optimisation

Layla Siebert, practice pharmacist, Salford

Case study 7: Future-proofing the workforce

Managing practice, GP and pharmacist expectations is essential. Within Sunderland's Primary Care Network model, we have tried to articulate the different skill sets that can be expected from pharmacists who are new to general practice, versus those who are experienced. It's also vital to recognise the time required for training and peer support, and the need for resilience to accommodate any extended absence from work.

We foresee each PCN operating as a unified pharmacy team (which will include pharmacy technicians) but linking up with all other PCN teams across the city. We also aim to create career structure within the model to reduce the risk of losing experienced pharmacists in the future. Collaborating with all pharmacist providers and pharmacists in the system will be key.

Megan Blythe, senior GP pharmacist, Sunderland

Summary

These examples give you some ideas about the benefits that clinical pharmacists can bring to your PCN. These clinical pharmacists have all been developing their roles over several years and access appropriate clinical supervision. Each clinical pharmacist needs access to a clinical supervisor, and they should work together to agree suitable roles and how the pharmacist will expand their scope of practice.

Do make sure that any clinical pharmacists you recruit are enrolled on the Primary Care Pharmacy Education Pathway[2]. This will support them to develop the knowledge and skills to progress and develop their role within the PCN.

For more information about clinical pharmacists visit the NHS England website at www.england.nhs.uk/gp/our-practice-teams/cp-gp/.

If you would like to be put in touch with one of HEE's North School of Pharmacy and Medicines Optimisation Clinical Pharmacists in General Practice Ambassadors please email medicinesoptimisation.north@hee.nhs.uk stating where you are situated.

References:
1 www.england.nhs.uk/wp-content/uploads/2019/03/network-contract-des-specification-2019-20-v1.pdf
2 www.cppe.ac.uk/career/pcpep/pcpep-training-pathway#navTop

North School of Pharmacy and Medicines Optimisation, Health Education England
Willow Terrace Road, University of Leeds, Leeds, LS2 9JL

Email: medicinesoptimisation.north@hee.nhs.uk
Website: www.hee.nhs.uk/our-work/medicines-optimisation