

Joint Policy Statement on General Practice Based Pharmacists

This document outlines the guiding principles for the evolving role of pharmacists working in GP practices to ensure patients obtain maximum benefit from the complementary skills and expertise of both professions, working together as part of the wider primary care team.

Summary and background

The Royal College of General Practitioners Scotland (RCGP) and the Royal Pharmaceutical Society in Scotland (RPS) have been working together for the past four years to increase collaboration between GPs and pharmacists and to break down the perceived barriers to joint working between general practice and pharmacy.¹

Both organisations have since highlighted^{2,3} the very different but key roles that pharmacists and GPs play in the long-term management of people with long term conditions and have recommended that collaborative working becomes the norm across Scotland. The publication of the Scottish Government action plan “[Prescription for Excellence](#)”⁴ has built on these recommendations.

The current workload pressures in General Practice highlighted in the RCGP “*Put Patients First: Back General Practice*” campaign launched in 2013 has prompted dialogue around different models of care utilising the skills of the whole extended primary care team to improve patient care. The RCGP Scotland Manifesto for the 2016 Parliamentary Election – “*Promoting General Practice*” - specifically recommended that all practice teams include a Clinical Pharmacist.⁵

¹ The Royal College of General Practitioners in Scotland and the Royal Pharmaceutical Society in Scotland, “[Breaking down the barriers – how pharmacists and GPs can work together to improve patient care](#)”, 2012.

² RPS in Scotland policy statement, [Pharmacists Working in GP Practices](#), June 2015.

³ RCGP in Scotland, “[A blueprint for Scottish general practice](#)”, July 2015.

⁴ [Prescription for Excellence](#), Scottish Government, September 2013.

⁵ “[Promoting General Practice](#)” The RCGP Scotland Manifesto for the 2016 Parliamentary Election.

We strongly believe that patient care can be improved through greater synergy between GPs and pharmacists. We believe that all GP practices would benefit from, and patients should have access to, the expertise of a pharmacist, helping patients to make the best use of their medicines, including minimising avoidable harm, and reducing unplanned hospital admissions as a result.

Elaine McNaughton, Deputy Chair (Policy), RCGP Scotland stated:

“Having had a pharmacist in the practice team for many years now I can see how this improves the quality of care within the practice by increasing patient access to the wider healthcare team and contributing to the demand for appointments by dealing directly with acute patient concerns related to their medication and with minor ailments. Working together in the management of long term conditions can help reduce unplanned admissions to hospital by improving patient safety in the overall use of medicines. Having the expertise in all aspects of medicines available to the whole team is a tremendous resource to free up GP time for more complex care”.

The RPS and RCGP remain keen to ensure that pharmacists who work in community pharmacies are further enabled to work with their GP and other health and social care colleagues to improve care of patients both in and out of normal practice opening hours (OOH). As recommended in Sir Lewis Ritchie’s Review of Primary Care Out of Hours Services, "Pulling Together", there are many opportunities for increased synergistic working to develop the role of community pharmacists to the mutual benefit of patients and the professions.⁶

The way forward

The different healthcare professions all bring unique skills sets to the primary care team. However, there are significant areas of commonality in providing patient care. It is important to eliminate duplication from the patient journey and create a dynamic and resilient workforce, able to respond to the individual needs of patients in GP practices in and out of hours (OOHs), in which each profession contributes to provide an appropriate and effective skill mix.

In addressing skill mix, the role of pharmacy technicians and administration staff in supporting pharmacists and GPs should not be overlooked. Supporting and developing repeat prescribing systems is one example of where a technician can improve overall efficiency in the practice.

Although many pharmacists have experience of working in GP practices and are already working at advanced practitioner level it will take some time to build the necessary capacity, and entry level roles will be required.

⁶ [The Report of the Independent Review of Primary Care Out of Hours Services](#) “Pulling together: transforming urgent care for the people of Scotland” November 2015 is an example of potential developments with community pharmacy.

The developing role of the General Practice Clinical Pharmacist will vary across different GP practices and in OOHs settings in the context of the skill mix of each unique multi-disciplinary team and the needs of the patient population being served. This will influence which specific pharmacist skills, relevant to their practice setting, are targeted for development as the role evolves over time and as capacity and experience grows.

The General Practice Clinical Pharmacist Competency and Capability Framework⁷ will be a useful mapping tool against which to agree initial roles and responsibilities, identify any learning and professional development requirements and work towards realising a pharmacist's maximum potential as an advanced practitioner.

The General Practice Clinical Pharmacist role is one that will require experience and many will be undertaking advanced clinical skills training (including consultation skills) whilst working towards an independent prescribing qualification.

We must therefore not be too prescriptive in our approach and whichever models of care are agreed in individual practices, there are some overarching principles which will ensure that patients obtain maximum benefit from the different expertise of all professions in the practice.

Box 1: Guiding Principles and the role of the General Practice Clinical Pharmacist

⁷NHS Education for Scotland. General Practice Pharmacist Competency and Capability Framework. A User's manual 2016

- **Working closely with GP colleagues, as part of the wider multidisciplinary practice team, the pharmacist's role should be professionally autonomous. However, we acknowledge that some will be working towards that and mentoring or peer support will be required, depending on prior experience.**
- **Whether employed by the practice or health board, pharmacists should always be linked to, and included in local health board governance arrangements. This is beneficial to all, ensuring the pharmacist has access to peer support including education and training, and the practice benefits from increased access to the resources of the health board primary care team.**
- **Professional accountability, including evidence of competence and accreditation, will remain within the pharmacists' jurisdiction, aligning with the profession's advanced practitioner framework.**
- **Pharmacists should be primarily patient-facing and deployed appropriately to address the gaps in patient care relevant to their expertise in all aspects of medicines.**
- **In a similar way to their GP and nursing colleagues, any non-patient-facing roles should be directly linked to improving the pharmaceutical care of patients.**
- **Pharmacists should be included in the clinical governance of practice prescribing.**

What will the General Practice Clinical Pharmacist do?

Whilst there is no universally adopted job description for this role the principal aim of the new Scottish Government funded⁸ pharmacist posts is to widen the primary care team and support GP practices. This must be seen in the context of all healthcare professionals working collaboratively to bring their own specialist expertise to the practice team.

Pharmacists have a particular specialist expertise in all aspects of medicines and will participate primarily in the delivery of medicines related care, but depending upon individual competencies, experience and the needs of the practice population, they can also contribute to delivery of wider clinical care. Depending on GP practice needs and health board policies the role will vary.

Box 2: Typical areas of responsibility of a General Practice Clinical Pharmacist.

⁸ *Primary care funding allocation for pharmacists in GP practices and additional Prescription for Excellence funding.* The Scottish Government PCA (P) (2015 16)

Face to face medication reviews to improve patient outcomes by:

- **Reducing inappropriate polypharmacy.**
- **Reviewing patients on high-risk medicines.**
- **Ensuring complete and accurate medication records including medicines prescribed out with the practice.**
- **Supporting patients through changes post-discharge and moving between care settings.**
- **Encouraging and supporting people with long-term conditions to manage their medicines.**

Other areas, include:

- **Contributing to multi-professional reviews including assessment for suitability for compliance aids.**
- **Being a point of contact for medicines information within the practice.**
- **Relevant and appropriate contribution to triage and treatment of common clinical conditions.**
- **Supporting acute and repeat prescribing by dealing with queries and authorising repeat or acute supplies when appropriate and within their competency.**
- **Dealing with patient concerns about their medication including adverse reactions and intolerance.**
- **Resolving issues arising from medicines reconciliation.**

There is scope for more pharmacist involvement working alongside GPs and nurse practitioners in OOH care. Models will vary according to local population need and will need to be evaluated but may include patient facing pharmacists in an OOH centre, contribution to appropriately targeted telephone triage, advice to community colleagues as well as providing their medicines expertise to the wider OOH multidisciplinary team.

The Appendix gives some real life examples of practice based working which illustrate how this role evolves over time and how pharmacists contribute to the practice team.

Competency and Capability

NHS Education for Scotland (NES) Pharmacy, in association with RPS, has developed a national competency framework³ for the General Practice Clinical Pharmacist (GPCP) role which is currently being developed as a joint piece of work between both GP and Pharmacy professions. The GPCP framework will be aligned with the RPS Advanced Practice Framework and has four levels of competency ranging from entry level to advanced practice level. The framework includes assessment of competence through clinical supervision including the use of a range of supervised learning events (SLE) such as, case based discussion, mini clinical examinations, multi-source feedback, and patient satisfaction questionnaires. In a similar way to their GP colleagues all general practice clinical pharmacists will be expected to participate in multi- disciplinary peer review e.g. practice based small group learning. (PBSGL)

To further support the competency framework NES Pharmacy has developed a supportive curriculum of training resources, all of which have had multi-professional input. These include e-learning resources and a series of masterclasses which will be multi-professional in delivery and meet training needs not delivered in the experiential setting. In addition the pharmacists will undertake the NES suite of clinical skills' courses and be fast tracked through independent prescribing courses where required.

Useful resources

NHS Education for Scotland, "*General Practice Clinical Pharmacists Competency and Capability Framework. A User's Manual*", to be launched September 2016.

Royal Pharmaceutical Society, "[A Competency Framework for all Prescribers](#)", July 2016

RCGP, "[The Future of GP Collaborative Working](#)", April 2016.

Royal Pharmaceutical Society, "[The ultimate guide for pharmacists working in or with GP practices](#)", 2015.

Primary Care Pharmacists' Association, "[A guide for GPs considering employing a practice pharmacist](#)", 2015.

Example 1: Cairn Medical Practice, NHS Highland

What did we do?

We helped a pharmacist develop primary care patient-facing skills and experience to include chronic disease management clinics and more recently management of common acute presentations.

What was our motivation?

We are a buoyant, healthy practice with a long experience in training. We had identified that we wanted to nurture and develop a modern general practice team in order to respond to workload demands and future recruitment pressures.

How did we go about it?

We helped a motivated pharmacist with some secondary care patient-facing experience in diabetes make the transition to primary care; already a prescriber, and well versed in secondary care diabetes, he initially sat in with our nurses who led the diabetic clinics, as well as with our GPs.

We drew up a list of those competencies which we felt that he would need, and prioritised his learning needs. We reviewed his progress against these regularly. He undertook some personal study and courses alongside this.

We set up supported clinics for him with a clear on-the-day GP to hand if needed. We provided mentorship and concentrated particularly on primary care consulting skills. Initially he stuck with diabetes until he was up and running in primary care, and we then expanded his remit to cover asthma, COPD and hypertension in a step wise fashion. Most recently, he is training to assess acute common presentations.

Where next?

Now that his patient-facing skills have developed satisfactorily and to a standard that we are happy with, we can start to expand his input into our working day looking more specifically at his medicines-related pharmacist skills.

Our practice now has a nurse practitioner and a pharmacist and there has been a noticeable impact on our working day, with positive feedback from staff and patients.

What were the keys to success?

- Buy-in from the whole practice team
- A motivated pharmacist, keen to learn and comfortable with exploring his blind spots and learning needs
- A solid mentorship based on a similar philosophy to GP Speciality Trainee training
- A clear cover system for on-the-day-clinical cover
- Clear instructions to administrative staff to fill his appointments appropriately
- Frequent review and feedback from the whole team, including patient feedback, to address any concerns.

Example 2: A personal perspective on her role in General Practice from an NHS Tayside Practice Pharmacist. Parkview Primary Care Centre, Carnoustie, Angus.

I started working with the Carnoustie practice in July 1997 as part of a project within Tayside. My role in the practice has evolved over the years.

I have always felt that the practice based Pharmacist is an integral part of the general practice team and is recognised as an important member of that team. Everyone in the extended practice team has immediate access to the practice-based pharmacist and pharmacist to them. This allows better understanding of the needs of the clinical team and of the patients and the pharmacist can usually provide the help and advice needed quickly. The GPs and Practice Nurses have expressed the benefits and the time saved in having a medicines expert immediately accessible in the building for all medicines queries particularly help with any unusual requests.

In the early years, a key objective of my role was to monitor practice prescribing and to guide prescribing practice often driven by health board priorities and targets. Driving and supporting cost effective prescribing continues to be an important task in my list of responsibilities for the locality and a good relationship with GP colleagues promotes engagement from everyone in our aim to make best use of resources. In conducting agreed prescribing audits, my contribution to the previous quality outcomes framework (QOF) was valued as was the help and support I could give to GP Registrars in their training with prescribing and audits, a recognised asset to a training practice.

I now feel a real sense of trust and confidence in my skill as the relationships within the practice team have strengthened over the years and in this context the scope of my role has widened considerably to enable me to share more of the practice workload. A key development to the tasks I can deliver was achievement of my independent prescriber status, with supervision from one of the practice GPs.

Clinical Role in medicines management

Non repeat and acute prescription requests, which would otherwise have gone to the GP, I am able to review, and in the majority of cases to issue the prescription and pass to the GP to sign. This can highlight requests for medication no longer indicated, or requiring clinical review, which I can now do on many occasions with direct contact with the patient. Alternatively, where appropriate, these are added to the repeat medication record. I am also able to deal with new medication concerns or intolerances presented by patients. Improved medicines management can assist the practice to reduce over-ordering of medicines and improve safety.

An early success in a specific area of health promotion several years ago, was the development of our multi-professional and community based approach to smoking cessation which won us the national GP Doctor of the Year Award in 2001 for our smoking cessation clinics. As this evolved, as an independent prescriber, I was able to take a more autonomous role in running Smoking Cessation clinics with our Health Visitor and audits of our activity revealed higher

than average cessation rates. This early experience has provided a good basis for developing other management clinics such as the chronic pain clinics.

I visit all the local residential care homes at least annually with a GP and often with the local Medicine for the Elderly consultant to do Level 3 medication reviews and have built up relationships with the care home staff who will contact me directly with medication issues which arise.

The benefits from joint working in terms of building experience and confidence for all parties has been truly reflected in our earlier polypharmacy project. Multidisciplinary medication reviews involved GP, Medicine for the Elderly consultant and pharmacist and prompted a much wider perspective to the discussions with patients and their carers on overall care often generating appropriate input from other healthcare professionals such as specialist COPD nurses. This patient-centred approach outlining risks and outcome benefits for the individual patient proved to be a constructive start to delivering realistic medicine.

NHS Scotland Polypharmacy Guidance⁹ highlights that there are many different ways of identifying patients who might benefit from a targeted medication review. Following our participation in the project, it was agreed that future identification of our patients for polypharmacy review should be through Multidisciplinary Team (MDT) meetings within Enhanced Community Support. Pharmacy team intervention at MDT meetings has ensured that patients struggling at home with lots of medication have been reviewed and assessed appropriately and given help to manage by way of pharmacist medication review and pharmacy technician compliance assessment at home. Most patients have some medication changes to improve adherence, improve safety, reduce likelihood of development of side effects and avoid unnecessary hospital admission. Good communication with the District Nursing (DN) team and implementation of different strategies by the technician has impacted positively on the DN service workload with regard to medicines administration and reviewing patient medication in this forum has saved on GP time compared to the previous polypharmacy review process.

With the support of the practice GPs, I am now about to lead on a project, supported by *Prescription for Excellence* funding, to run and evaluate medication review clinics for patients with multiple conditions developing on from the single chronic disease review clinics currently run by specialist pharmacists.

Interface with community pharmacist, secondary care and other healthcare professionals

I work closely with and deal with queries from local community pharmacists, which would otherwise go to the 'on call' GP. These queries include clarification of doses, substitution of alternatives when there are supply problems and assistance with medicines reconciliation especially when patients on monitored dosing systems are discharged from hospital with changes to regime.

Medicines reconciliation on discharge from hospital often prompts clarification and confirmation with secondary care colleagues reducing the potential for error

⁹ [Polypharmacy Guidance](#). March 2015 SIGN.

and improving follow up arrangements and similarly with recommendations from out-patient clinics. Dealing with discharge documents reduces time spent by the GPs on medicines administration.

Working with the local community dietician has helped to ensure ongoing prescribing of oral nutritional supplements is justified.

Education and quality improvement role

For many years I have led the monthly prescribing meetings with clinicians and more recently the community pharmacist joins some of the meetings. I deliver practice education sessions and update the clinical team on the latest prescribing changes, new local and national guidance and MHRA alerts. There is also the opportunity for discussions around prescribing indicator reports and we agree areas for improvement. This also includes regular review of the practice repeat and acute prescribing systems, practice held drugs and controlled drug policy.

I see much potential to further expand the role of practice Pharmacist which for me has evolved and developed with an increase in experience and confidence achieved through solid relationships and feeling valued.