Primary Care Transformation WebEx
Pharmacy in Primary Care
23 November 2017
Webex Recording: [View Recording]

**Presenters**

Jennifer Wilson, Nurse Clinical Lead, Healthcare Improvement Scotland

Alison Strath, Chief Pharmaceutical Officer, Scottish Government

- See Alison’s presentation [here](#)

Clare Morrison, Senior Clinical Quality Lead/Lead Pharmacist (North), NHS Highland

- See Clare’s presentation [here](#)

Elaine Paton, Senior Prescribing Advisor, NHS Greater Glasgow & Clyde

- See Ruth’s presentation [here](#)

Mark Easton, National Clinical Lead, Healthcare Improvement Scotland

- See Mark’s presentation [here](#)

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Professions represented on the call:

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<th>Profession</th>
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<tr>
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Other professions identified in the chat box:
Public Partner, Medication Safety Advisor, Evaluation, Patient Representative, Prescribing Analyst (2), GP (2), Programme Manager, Improvement Support Manager, Project Manager

Question:
Where are you dialling in from?

Where are you “dialling in” from?

Other locations identified in the chat box:
Grampian, Highland, Western Isles
Presentation: National Perspective – An overview of the Pharmacotherapy service (Alison Strath, Principal Pharmaceutical Officer, Scottish Government)

From the chat box:
- Will pharmacists working in GP practices be encouraging patients to register with and use the same Pharmacy? This is really important especially in larger towns and cities
- Realistically in the next 2-3 years how many Pharmacists will be working in GP practices? What is the vision? 0.5 whole time equivalent (wte) per practice?
  o From our experience to date 1 per 10,000 will not deliver what has been stated as 'core' needs, especially in urban practices
- What are the legal aspects for IPs around authorising repeat prescribing?
- I'm in a small dispensing practice, and we have a board-employed pharmacist working with us. We'd like to integrate her more effectively in our team, but because our building is so small, we can't offer her any office space. She is therefore dialling in remotely, which means we never see her and we are probably not using her time effectively. So my point is that this project has to acknowledge some of the wider issues that affect how practices use support.
- Should medication reviews not be part of core service?
  o I agree reviews should be core and are not specialist roles. Can't work as an MDT is you are restricted doing all acutes and repeat for the majority of time
  o patient facing roles should be part of core service in line with achieving excellence in primary care

Presentation: Local Perspectives: Pharmacists working in GP Practices (Clare Morrison, Senior Clinical Quality Lead/Lead Pharmacist (North), NHS Highland)

From the chat box:
- I'm not sure aligning 'tasks' against levels really works, as we want all grades of staff to have a balanced portfolio to allow development and ensure recruitment and retention. This is the pilot model we are working to.
  o Important to develop a clinical patient facing role for all members of the team that is not just task/process driven.
    ▪ I cannot agree more. You need to speak to patients. If 50% of meds are not taken correctly then you must speak to folk to improve that
- Loving the idea of a pharmacy technician supporting technical medicines management. Would fit really well with IJB plans regarding medicines management in the frail elderly
- Interesting to be able to establish hours saved with serial prescribing....costings too?
- We are just starting our relationship with our pharmacist in the practice - are you willing to share some of your protocols to help develop our service locally?
  o yes, happy to share any protocols etc
- I often hear of pharmacists struggling to get a GP mentor for the Independent Prescribing course as the GP 'doesn't have the time'. How can this be supported more?
- We need to be careful we don't just soak up the stuff the GPs don't want to do and doing our own profession a disservice as a result.
  o would absolutely agree with that

- The jobs list in the GMS contract is quite prescriptive in terms of Tech and Pharmacist roles. Is anything being done to moderate GP expectation? Surely we should be deciding who is best to perform each role (e.g. a Tech can do Med's Rec to a very high standard)
  o Yes there definitely needs to be more flexibility around this as no two practices are the same, and therefore cross covering (unless processes and ways of working within general practice are standardized, and there are excess staff in post) will be challenging

- Is there scope to accommodate housebound patients who may need a home visit?

- It's crucial to see the new roles - ANPs / Pharmacists / MSK physio as key members of the Primary Health Care Team (PHCT) and have sufficient support from appropriate members of the PHCT. This could be GPs but would also expect peer support / learning to develop the service
  o Need to educate the public to accept taking advice from folk other than the traditional GP
  o Also key to educate the public on new roles - some people still think they’re being "fobbed off" if the contact isn’t with the GP
  o Except do people know what a pharmacist’s qualifications and experience are - are they not just the people that fill the prescription that the doctor writes?? Perhaps worth a thought as to why people are resistant and how we can help them understand what’s in it for them and why a pharmacist is the best person to see in certain circumstances?
  o Agree that pharmacists are better from the patient’s viewpoint, still need to educate patients that GPs are not the only folk that can help them
  o In relation to comment on public understanding the role......is pharmacotherapy really the best name?
    - GP Pharmacist is easier for public to understand
    - We chose our names to reflect the existing roles in the practices - they are used to having Advanced Nurse Practitioners so Advanced Pharmacist Practitioner followed naturally & made sense to practices

- Good to see early uptake of Attend Anywhere. I think this can bring significant leverage to clinical time and reduces travel for both clinical staff and patients.

- The critical element is to establish per 1000 population what the medicines management/ pharmaceutical care needs are, and what the associated workforce planning pressures will be. Important that newly qualified pharmacists and techs are given time to develop as assuming a primary care role newly qualified would be difficult. With financial strains on Boards / IJBs and the need to adopt long term planning in a short term funding arena, how will this be taken forward?
  o There is no magic sum that sets out how many hours of pharmacist time should be allocated per 1000 patients. And some practices are happier than others to allocate work & time than others.
    - But unless we have this, planning is difficult

- Great work up North!
  o Wonderful to hear the innovation up north. Very organised and forward thinking service Clare :-)

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Presentation: Local Perspectives – Partnership working across GP practice and Community Pharmacy (Elaine Paton, Senior Prescribing Adviser, NHS GG&C)

From the chat box:
- Does the jobs list in the GP contract reflect any of the pilot work that has been done since 2015 phase of investment?
  - The proposed new ‘blue book’ for the new GP contract is currently out for consultation with Local Medical Committees and has not yet been voted on. The role of GP pharmacist (or whatever title we prefer) is embedded as a concept within the contract. However, the resources to support this are very vague, and there is no discussion as to how boards decide how many GP pharmacists to employ. Practices that already employ their own pharmacists are unhappy that the boards will be responsible, and feels this threatens their nice teams, or that they will lose control of the job description and time allocation, as this will be set by boards and not practices.
  - Please do not forget the patient in any discussion on whether the Board or GP practice is in control of the service, it should not make any difference to how we deliver the service to the patient.
  - the new GP contract is nearly complete and it sets out who employs/funds GP pharmacists.

- More work needed on sharable data - data standards and interoperability. Need to adopt current international data/messaging standards rather that create "home grown" standards. This would be in line with thinking elsewhere in eHealth and would help greatly towards getting to a single version of the "truth" for medication records.
  - Couldn't agree more!
  - I hope that data sharing standards etc. will not get in the way of the patients receiving the help and advice they need.
  - The whole point of data standards is for them to facilitate better service/advice to patients - current siloed data means that virtually nobody knows what the real picture looks like.
  - I think the new contract says that the data will be more easily shared - new data arrangements in the new GP contract.
    - I know GPs who still think that patient data is owned by the GP; nothing could be further from the truth

- Good idea to separate serial scripts from Pharm Care CMS. Got new name for service yet?

- What is the role for paperless prescribing, both acute and repeat / serial to expedite the mechanics of the process which are historical but deliver little value?
  - Vital to the direction of travel

- Will the GP have access to the level 1 Med Review or know that this is done? Or is this in the pipeline?
  - If contained in the PCR - currently no. If review done on GP clinical system - yes.
  - A level 1 medication review carried out in the new PCR v13 will contain a way to share this with GP practice using a similar model to the SBAR.
    - Thanks Elaine, that’s quite exciting.
  - Now have some movement towards joint data controller status - the right noises are coming from the ICO about this.
    - What does Joint Data Controller mean?
Pharmacy First is doing well in Ayrshire and Arran too….looks like good way forward and helps reduce workload in GP practice, plus raises profile of community pharmacy in eyes of the public.

How do we best communicate the care issues and prevent duplication of work? To PSPs? GP? eSBAR?
- Communication of care issues is part of the ongoing redevelopment and refresh for CMS. Acutely aware of the need to avoid duplication or replication.
- We know the SBAR format works, so to move away from that in any significant way could have negative outcomes. However, we need to consider how we move that information around (and I mean not moving "images" of that information e.g. PDF/Word/etc) and make it available to those who have appropriate levels of access to the data. So again data and messaging standards are important to be considered at the outset.

Resource modelling is vital to ensure that you can say we will do 'all' xyz. We know from the pilots what time is allocated to do what volume of tasks (which at present doesn't include repeats)…. I reckon to fulfil the asks of the contract you would need about 1.5wte per average practice (5000) and ensure cover
- so over 2.5k pharmacists…..not including community
  - If you want to allow a balanced portfolio and allow time for traditional prescribing support still to help maintain financial balance then yes about 2.5k pharmacists….you think they are out there ready to start in the next 3 years?
### Q&A Session:

Q: Is there any scope to accommodate house-bound patients that may need visits from pharmacists?

A (Clare Morrison): Looking at using the Attend Anywhere (AA) software for this precise reason at the moment. Could have AA on an NHS device (for example a tablet), and this could be taken out to house-bound patients, whereupon they could have a consultation with the pharmacist or other clinician wherever they are based. A great opportunity to deliver services in a much more patient-centred way.

Q: In your experience, have you been encouraging patients within practices to register to the same pharmacy? This is really important, particularly in larger towns and cities

A (Clare Morrison): Within 2 areas which we were focusing on increasing serial prescribing, we couldn’t issue a serial prescription until someone was registered with the pharmacy. In each town, there were 3 x pharmacies but only 1 GP Practice, thus we had to encourage patients to register to a pharmacy of their choice. One of the reasons we didn’t reach the levels of serial prescribing as hoped was because those registrations did not always happen (when following up with patients, common response was “I didn’t get round to it”), so patients are going to the same pharmacy, but not registering. This is a problem that needs to be tackled.

Q: How did you establish a relationship of GP Practices with community pharmacists, in a practical sense?

A (Elaine Paton): Not so much about establishing relationships, as we have to acknowledge that there has been a long-standing relationship between the patient, the GP and the community pharmacist across the country. When we were doing this particular piece of work (Partnership working across GP practice and Community Pharmacy) we were asking pharmacies and GP Practices to work on a 1:1 scale to test the concept. Reality is that we have so many practices running with serial prescribing now that this isn’t really needed any more. It’s about letting the patient choose which pharmacy is most ideal for them to collect their regular medication and letting the dynamics that are already in existence flow.

Q: I often hear of Pharmacists struggling to get a GP mentor for the IP course because they don’t have time. How can this be supported?

A (Alison Strath): We have been discussing as part of the GP Contract arrangements how they can get dedicated time for mentorship. This extends to other members of the multidisciplinary team as well (for example Allied Health Professions).

Q: How do we educate our patients not only in pharmacy but the wider MDT?

A (Clare Morrison): Started by talking to Practice Participation Groups about services that they were working on. Through them, we were able to include information through channels such as practice newsletters that they construct. Did local work with local press talking about their role. Hugely positive response from patients about this. This was happening in areas where GPs were so stretched that pharmacists simply had to deliver these services. We, as pharmacists, can provide these services and patients responded really positively that their GP services could keep going as a result of the input of the pharmacists.

A (Alison Strath): It takes time to win hearts and minds and getting people to use services differently, but we accomplish this by doing the work well. There is a piece of work around GP Practices sustainability that Scottish Government are leading on in terms of signposting, which we can certainly use the findings of.
From the chat box during Q&A session:

- Do we know how data transfer is being discussed with the new primary care GPIT re-provisioning?

- Agree that pharmacists are better from the patient's viewpoint, but we still need to educate patients that GPs are not the only folk that can help them

- Attend Anywhere - does this not need network or broadband?
  - We are currently testing Attend Anywhere in our practice for follow up med reviews and yes it does need broadband
  - Attend Anywhere needs sufficient internet connection to run a YouTube video, can be on a mobile device or a computer
  - Attend Anywhere sounds good - would be nice one day for patients to be able to access some of their record etc. I live in hope....
    - Ongoing SWAN infrastructure upgrades should help with this as greater bandwidth needed for new GP systems. In addition increasing the availability of health Wi-Fi provision will also help, but Rome wasn’t built in a day, and some remote and rural areas will continue to be challenging.
    - Yes, we only have 70% 2g coverage and the new broadband roll-out has not delivered access to broadband in most of the areas it listed - including my own home.

- That project is focusing on moving the current GP legacy system onto current and next generation systems. But these are focused for use in GP practice - although all prescribers are being accommodated in the specifications.

- Does authorising repeats mean doing an annual medication review or does it include IPs signing the bundle of daily scripts?

- Thank you all for the presentations. Great to hear how the GP contract is opening the doors to Pharmacists, The innovation in Highland, the developments in community pharmacy (PGDs & PCR) and the pilot work currently being carried out.
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Improvement Hub (ihub)

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB
0131 623 4300

www.ihub.scot

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP
0141 225 6999