Embedding clinical pharmacists in GP practices (Healthy Prestatyn)

Betsi Cadwaladr University Health Board

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Summary of the Project

Align with the principles of prudent healthcare

Only do what only you can do

- To extend the role of pharmacists within primary healthcare
- Pharmacy leading the management of medicines in practice
- To release GP capacity relating to medicines management work and issues

Co-production

- To increase the opportunity for level 3 medication reviews with health professionals

Do no harm

- To reduce polypharmacy
- To reduce medication related harm and waste
- Improve medicines governance and reduce waste

Why was this chosen?

- Over last 3 years, Prestatyn GMS contractors were experiencing GP recruitment problems.
- Pacesetter funds allowed input of a 1.0wte clinical pharmacist to support medication reviews, repeat authorisation and resolve medication queries.
- This reduced the “medicines” related GP workload.
- Three GMS contractors resigned, as of 1st April 2016, Prestatyn has LHB run primary care service, using a wide pharmacy mix to reduce medicines related GP workload – “Healthy Prestatyn”.

What would Success look like?

- The pharmacist in the MDT is the 1st point of contact for medicines related queries.
- Pharmacists undertake regular targeted level 3 (face to face) medication reviews.
- Patient centred outcomes for patients following medication optimisation and “expert” patients developed.
- Evidence of reduced medicines related harms and admissions to hospital
- Evidence of reduced polypharmacy
- Improved interface communications
- More appropriate use of General Practitioner time.

What are your Process & Outcome Measures?

All 3 projects use the same process & outcome measures:-

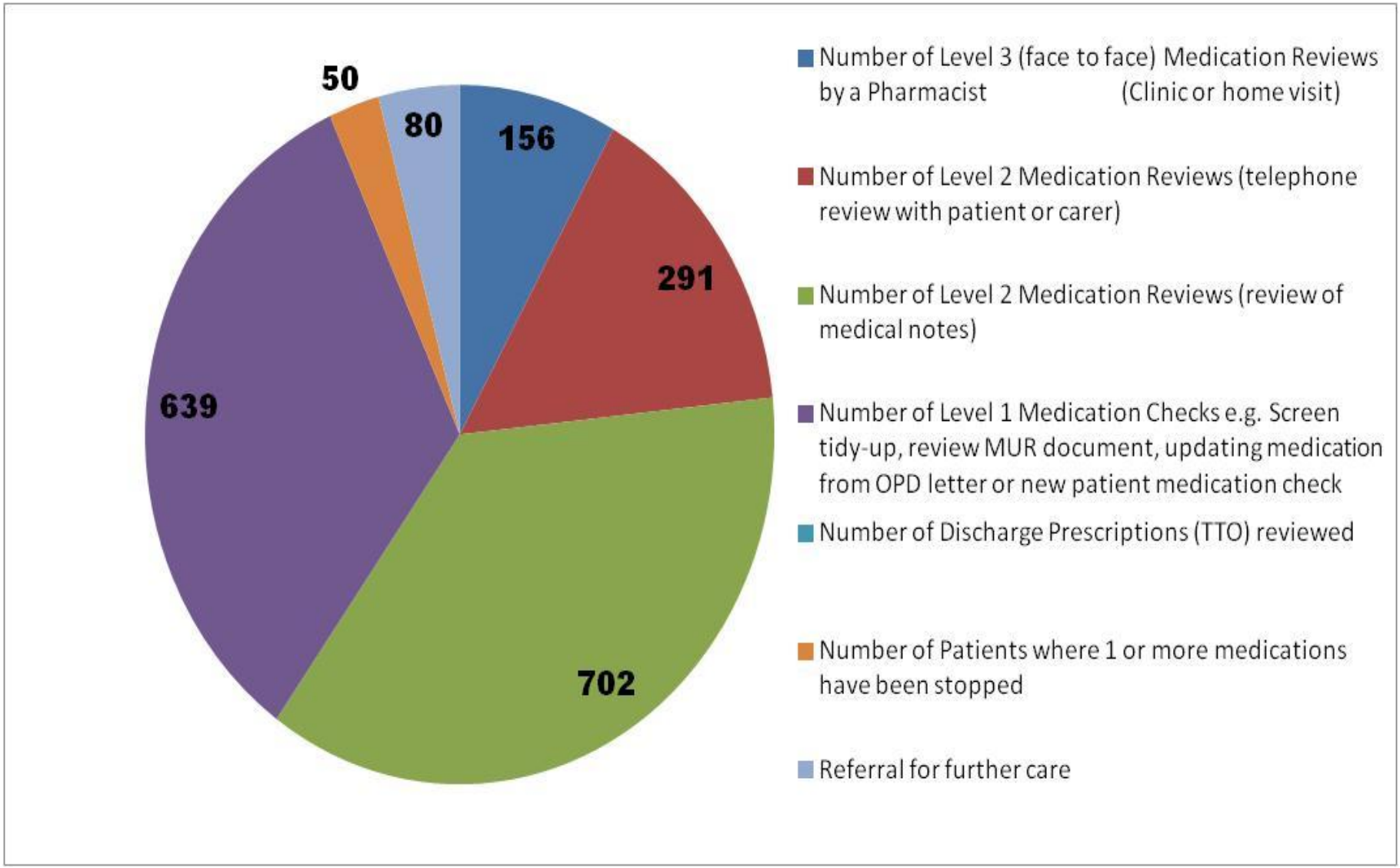
Process

- Number of Level 3 (face to face) Medication Reviews by a Pharmacist (Clinic or home visit)
- Number of Level 2 Medication Reviews (telephone review with patient or carer)
- Number of Level 2 Medication Reviews (review of medical notes)
- Number of Level 1 Medication Checks e.g. Screen tidy-up, review MUR document, updating medication from OPD letter or new patient medication check

Outcome

- Number of Patients where 1 or more medications have been stopped
- Number of referrals for further care

What will be your Outcome Measures? Central Area



Will you have any Balancing measures?

- On the spot concerns
- Complaints
- Patient feedback evaluation
- MI queries
- Pathology labs workload
- GP workload to train and mentor the pharmacists

Dear AMD

You won't remember me I'm sure , but when you presented the new GP arrangements to Prestatyn Town Council I was the councillor who questioned the wisdom and necessity of having a pharmacist on the team. Rob had just reviewed my annual blood test and prescriptions. Wow! What an improvement on the old way of doing things. He gave me an in depth review and risk assessment, which I have never had before, and prescribed a safer substitute for one of my drugs. I was most impressed by this and by Rob himself, who was pleasant and patient.

Please pass on my thanks to him and to all concerned

Best wishes DT

What did you Learn ?

1. Recruitment process slow
2. Early concerns regarding insurance and liability for pharmacy staff.
3. New role, unique skill set required – relating to clinical knowledge, behavioural and influencing skills
4. Clinical / competency boundaries
5. Wider MDT and practice staff understanding of what pharmacy can do and cannot do!
6. Clinical knowledge as valuble as IP to MDT
7. Teams take time to develop
8. Issues regarding sustainability funding – historic role vs newer service delivery. A change ofservice model.

How does this align to Ministerial priorities?

- **Achieving service sustainability**
  - Introduces pharmacists in to the skill mix to support holistic service delivery
  - Reduces medicines related workload burden for GPs
- **Improving access**
  - Releases GP time to focus on management of more complex patients, and enable earlier diagnosis of new conditions
- **Moving services out of hospitals into community settings**
  - Prevents admissions to hospital from medicines related harm
  - More frequent face to face review helps to develop patient expertise in managing their condition and medicines

Next Steps

1. Continue to appraise the current Healthy Prestatyn model, and pharmacies contribution
2. Identify next steps, with further development of the pharmacists IP roles and identify extended roles for community pharmacists
3. To rollout effectively and sustainably we need a integrated pharmacist career development pathway
4. Develop a formal mentoring programme with support from peers and the MDT that the pharmacist work in
5. Need to establish governance framework to support these pharmacists as either NHS or independent employees
6. Continuing funding is needed to support the development of further pharmacists to continue and expand these roles
7. Identify funding from the wider health community to fund development opportunities and innovative posts

Discussion – 21st Sept 2016

- Pharmacist in the MDT is first point of contact for medicines related queries. Focus on MURs & authorising repeat medications (especially for salaried and locum GPs)
- Impact on reduced polypharmacy / inapprop antibiotics and steroids – reduces admissions
- Effective at empowering patients at consultations
- Improve access to appropriate treatment for patients – only go to GP for medication issues when necessary. Need for clarity on boundaries and competencies for GP vs pharmacist
- Need framework for pharmacists (undergrad course is changing):
- Clinical competency and boundaries
- Training plan
- Protected workforce
- Mentorship
- Indemnity
- New roles and skill sets, with wider understanding of scope of role
- Teams take time to develop
- Linking in community pharmacy – important skillset; currently work in isolation
- Need a governance framework and funding