

# Clinical pharmacist roles in primary care networks

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**Clinical pharmacists are important members of the multidisciplinary team within primary care networks (PCNs), which were established across England in July 2019. This article discusses the roles that will be expected of clinical pharmacists within PCNs and how these roles are likely to develop in the future.**



The NHS Long Term Plan is designed to set the context and themes for the NHS in England over the next 10 years.<sup>1</sup> The Long Term Plan introduced the blueprint for primary care networks (PCNs) of local GP practices and community teams through which all network resources will flow.<sup>1</sup> Established in July 2019, PCNs cover populations of between 30,000 and 50,000 people across England. The aim is to have a fully integrated community-based health team consisting of a range of disciplines such as GPs, pharmacists, district nurses, dementia workers, community geriatricians, physiotherapists and podiatrists/chiropractors.<sup>2</sup>

PCNs can also receive funding for additional staff to work as part of an extended multidisciplinary team including clinical pharmacists, physiotherapists, physician associates, community paramedics and social prescribing link workers through the Additional Roles Reimbursement Scheme.<sup>2</sup> PCNs can recruit one whole time equivalent (WTE) pharmacist per 30,000 patients in the

first year, increasing in number up to a potential total of 7000 across England by 2023/24.

The scheme provides a recurrent 70% of the additional employment costs for a pharmacist. However, PCNs may choose to spend this resource on other additional staff such as physician associates, ie the fund is not ring-fenced for pharmacists. The PCN can decide where to deploy the pharmacist but the individual's role is likely to be initially spread thinly across member practices, eg a practice of 10,000 patients would receive a pro-rata weekly allowance of only 12 hours.

## Role of NHS England-funded clinical pharmacists

NHS England expects the pharmacists to be part of the multidisciplinary team, clinically assessing and treating patients. They will be prescribers or training to become prescribers. Pharmacists will “take responsibility for the care management of patients with chronic diseases and undertake clinical

medication reviews to proactively manage people with complex polypharmacy, especially the elderly, people in care homes, those with multiple co-morbidities (in particular frailty, COPD and asthma) and people with learning disabilities or autism".<sup>2</sup> The role is therefore expected to be predominately patient facing.

To perform these roles, pharmacists will need to have a relatively high level of experience and skills. More junior pharmacists will need supervision by a senior pharmacist, akin to the past programme funded by NHS England in which a senior pharmacist oversaw a team of more junior pharmacists. Additional training will be provided by the Centre for Pharmacy Postgraduate Education (CPPE) and pharmacists will need support from GPs. However, pharmacists will need to supplement CPPE training by seeking opportunities in the workplace, eg developing digital skills, and practicing new skills, eg medication review consultations and conducting audit and feedback.

## What else is are NHS England-funded pharmacists expected to do?

### Leadership

NHS England expects clinical pharmacists to provide leadership on person-centred medicines optimisation (including ensuring that prescribers in the practice conserve antibiotics). This role will require pharmacists to develop skills in quality improvement, including methods such as audit and feedback, and running education meetings with the general practice and wider healthcare team.<sup>3</sup> Pharmacists will be in a good position to advise and develop standardised approaches to care across the PCN, eg setting up joint formularies on practice clinical information systems or procedures for safer monitoring of high-risk medicines.

Practices within PCNs will have been formed on a geographical basis and may have different values, infrastructure and management capabilities, as well as varying patient populations, eg different levels of deprivation and healthcare needs. Pharmacists will therefore need to have skills in negotiating changes and manag-

ing expectations placed upon them by member practices.

In order to support the network practices, high-quality data will be needed to measure performance. Practices will have signed a data-sharing agreement to allow the network, CCGs and NHS England to produce comparative data, eg the Network Dashboard. However, pharmacists will need to be capable of creating and analysing data that relates to prescribing from practice clinical information systems (eg EMIS, TPP SystmOne), to provide information on locally identified issues, eg anticoagulant prescribing rates for stroke prevention in patients with atrial fibrillation.

### Management of higher risk prescribing

Clinical pharmacists are also expected to play a central role in managing medicines that are part of shared-care agreements, such as setting up systems for safe monitoring and prescribing of high-risk medicines as part of the GP Quality and Outcomes Framework (QOF).<sup>4</sup> In the first instance, this is limited to quality improvement in the following areas:

- NSAID use in patients at significant risk of complications such as gastrointestinal bleeding
- Better monitoring of potentially toxic medications through a focus on lithium prescribing
- Better engagement of patients with their medication through a focus on valproate use and pregnancy prevention.

It is likely that this list will expand over time, and so pharmacists should not restrict their work to these three medicine groups. The opportunity must be taken to set up systems for monitoring a range of medicines (eg DMARDs, amiodarone) and avoiding prescribing in patients where a medicine constitutes a high risk (eg benzodiazepines in severe frailty).

Practices will have to evaluate the current quality of their prescribing safety, identify areas for improvement, and set goals to improve performance.<sup>4</sup> In order to improve collaboration between practices and community pharmacists, and to share learning practices, they will need to participate in a minimum of two network

peer review meetings. As leaders in medicines safety, pharmacists are likely to lead on this work and to facilitate these meetings.

### Communication and networks

PCN pharmacists will need to develop relationships and work closely with pharmacists across networks and the wider healthcare system. This includes liaison with specialist pharmacists, eg mental health pharmacists, to address issues such as reduction of inappropriate anti-psychotic use in people with learning disabilities, as well as liaison with specialist pharmacists regarding anticoagulation management.<sup>2</sup>

This focus on improved communication is aimed at increasing patient safety; for example, improving transfer of care from hospitals and specialist care, and ensuring prescribing and monitoring intentions are continued after hand over of care. Improving communication between practice-based and community pharmacists (and vice versa) will also be important; for example, regarding changes of medicines to patients at higher risk, such as those in care homes, or changes to prescribing of higher risk medicines.

### Digital skills

In order to work effectively in general practice settings, pharmacists will need to develop digital skills, such as navigating the clinical information system, setting up digital formularies and decision-support messages, managing the electronic transfer of prescriptions (ETP) system, and analysing prescribing data. Practice pharmacists often find that once they have developed these skills, they become the 'go-to' person for helping other team members with data usage and analysis, and setting up prompts and reminders.

## National service specifications

The seven national service specifications will be phased in over the next few years (see Table 1).<sup>4</sup> Details of what will be included in each specification and how they will work is yet to be decided. In all seven, there is a potential pharmacy role. The first national service specification

National service specifications	Start date	Potential pharmacist roles
Structured medication review and optimisation	2020/2021	Main role for practice clinical pharmacists Focus on reducing over-medication and medicines no longer needed (eg deprescribing in the frail elderly/ stopping low-priority prescribing) and inappropriate use of antibiotics Appropriate patients can be identified through computer searches, eg using the electronic frailty index and STOPP criteria
Enhanced health in care homes	2020/2021	Identification and coding of people who live in care homes and then providing medication reviews, eg on arrival, after admissions, after episodes of worsening health status and routine six-monthly reviews Support to care home staff on medicines policies Training of staff, eg on safe medicines administration
Anticipatory care	2020/2021	Focus on patients at risk of unwarranted health outcomes and those receiving palliative care Pharmacy input is likely to focus on medicines optimisation for the frail elderly (using the eFI to identify high-risk individuals) and then supporting GPs, social services and community service as part of multimorbidity reviews to optimise prescribing
Personalised care	2020/2021	Pharmacists will need to be able to refer to social prescriber link workers, eg for physical activity before medicalising management of high blood pressure
Supporting early cancer diagnosis	2020/2021	Clinical pharmacists will need to play a role in raising awareness with patients of symptoms suggestive of cancer and also to encourage attendance at screening programmes
Cardiovascular disease prevention and diagnosis	2021/2022	Medicines optimisation (including lifestyle advice) for patients at high risk of developing cardiovascular disease including initiation of statins, antihypertensives and dose optimisation, eg following NICE guidance on high-intensity statin therapy <sup>11</sup> Offering anticoagulation to patients with atrial fibrillation who are not on treatment despite no contraindications <sup>12</sup> Medicines optimisation (drugs and doses) for patients with heart failure, eg loop diuretics, beta-blockers, ACE inhibitor/angiotensin II-receptor blockers and aldosterone antagonists <sup>13</sup>
Tackling local inequalities	2021/2022	Creating searches/using QOF/PCN dashboards, etc, to identify people not prescribed treatments Calling patients in for reviews to offer treatments Providing leadership on public health issues where patients could benefit from a medicine, eg vaccines, smoking cessation

**Table 1.** The seven national service specifications in the primary care network (PCN) contract and how pharmacists can contribute<sup>4</sup>

will be on structured medication reviews and optimisation. This is likely to be led by pharmacists and based on the NICE guidance.<sup>5</sup>

As the workload could be large, reviews will need to be targeted. The guidance says the focus will be on reducing over-medication.<sup>4</sup> Deprescribing of unneeded medicines is most likely to be beneficial in the frail elderly, who are more at risk of medicine harm. Pharmacists will need to be familiar with how to identify potential frailty (eg using the e-Frailty Index [eFI] tool), and will need to gain skills and confidence in conducting consultations involving deprescribing and how to follow up patients.<sup>6</sup>

### Personalised care

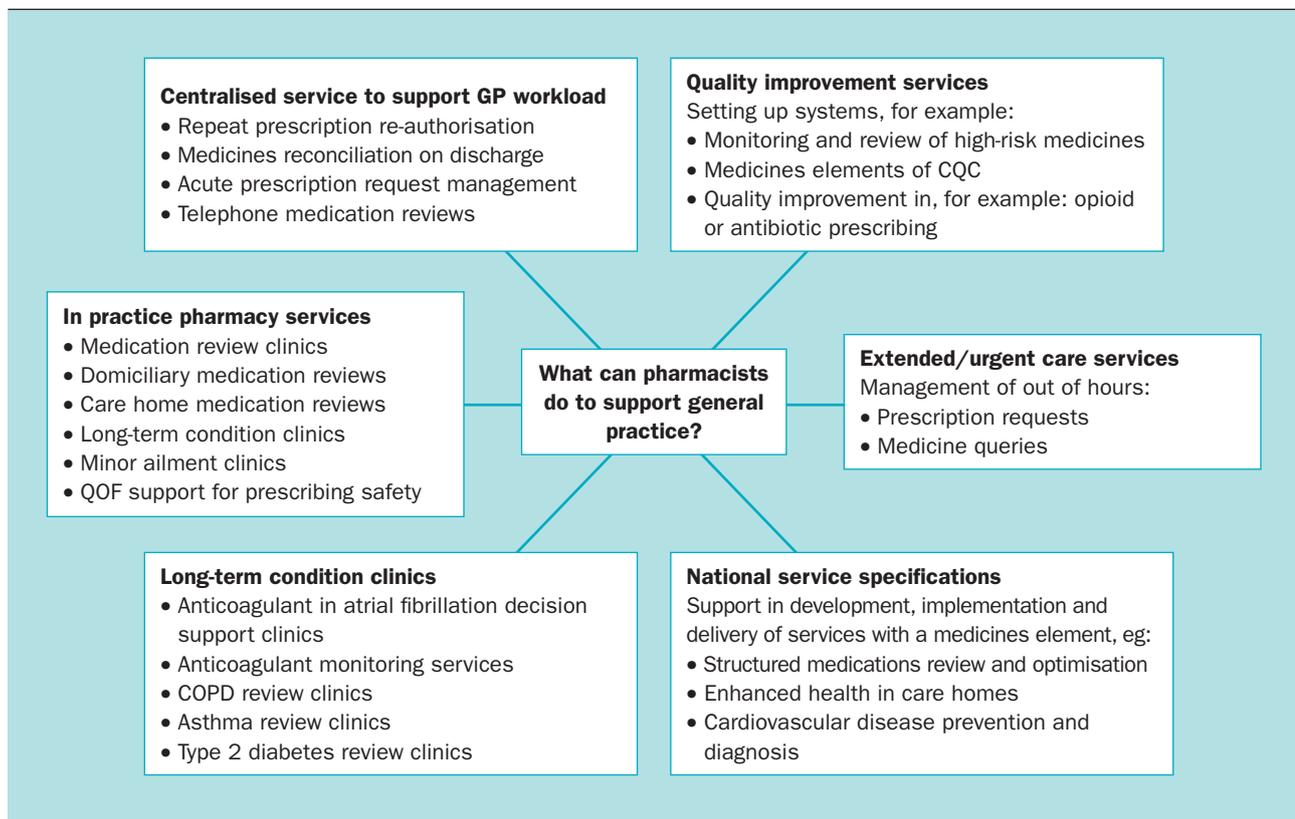
The aim of personalised care is to avoid over-medicalising care.<sup>2</sup> Based on models that have already been tested in the NHS,<sup>7,8</sup> it is anticipated that social prescriber link workers will take referrals initially from PCN members and a wider range of agencies, eg local authorities, police or community pharmacists.<sup>8</sup> All pharmacists will know how to access and make use of this resource. The aim is to produce personalised care plans that reconnect people to community groups and statutory services. Evidence suggests this de-medicalising of care can substantially reduce GP appointments.<sup>7,8</sup> Examples of such services include provision of information and advice, physical activity, befriending and self-help, and support with state benefits.

### Shared savings scheme

NHS England has proposed developing a standard national prescribing incentive scheme in 2019/20.<sup>4</sup> Many of these schemes are based on more cost-effective prescribing and prescribing quality improvement. Traditionally, this work has been carried out by CCG pharmacists and technicians. Going forward, this could be a role suited to technicians working for PCNs.

### What do GPs need from practice pharmacists?

The types of roles that can be performed by practice pharmacists are



**Figure 1.** Potential roles for clinical pharmacists in supporting patients in general practices. Courtesy of Prescribing Support Services Ltd

illustrated in Figure 1. A large proportion of GP time is taken up with medicine-related work such as repeat prescription reauthorisation, medication reviews, medicines reconciliation on discharge, and acute medication requests. Some of these services could be offered in the form of a centralised service. A centralised ‘hub’ service allows for delivery of a service to all practices, five days a week, as it improves efficiency for a network. For example, less time is taken up with travel to practices, and referrals or query answering can be dealt with immediately even if not physically at the surgery.

There is potentially a very large amount of work to be undertaken by practice pharmacists and what can be delivered will depend upon the availability of a pharmacist workforce, the willingness of PCNs and individual practices to fund posts, the skills and knowledge of the pharmacist(s), and the vision of the PCN to expand pharmacists’ roles.

### Limitations of NHS-funded PCN pharmacist posts

The NHS England programme requires the majority of the pharmacist’s time to be patient facing. The programme requires a focus on medication reviews in frail older people with multimorbidity and polypharmacy. These are the most complex types of reviews, and in my experience take 45 to 60 minutes (from initial note review and consultation to implementation of agreed changes).

While medication reviews in the frail elderly are very necessary and important work, it will mean pharmacists in the NHS England-funded programme will not have time to perform the activities that are important to the general practice in terms of reducing GP administrative workload. This is a point also made by Professor Tony Avery, who emphasised that “*although pharmacists [in the clinical pharmacists in general practice-funded pilot scheme] may sometimes ease GP workload the majority of the impact of practice-based pharmacists will be on*

*quality and safety*”.<sup>9</sup> The NHS-funded posts should therefore be considered to be in addition to existing practice pharmacist posts.

### The way forward

The PCN clinical pharmacist scheme offers an opportunity for making pharmacists based in general practice the norm. However, the workforce demands on GPs will not be met solely through this scheme, and GPs and PCNs should consider how else a pharmacy workforce can support demands on services. The PCN programme should be viewed as a training programme to provide a fully competent pharmacist workforce in the future. Training from the CPPE will be provided, but much of the learning and development of new skills will need to take place in practice, including subjects that can’t be delivered in a class room, eg digital skills.

In time, the clinical role of pharmacists is likely to develop, with advanced clinical pharmacist practitioners provid-

ing a greater level of patient care. PCNs will therefore have pharmacists with different levels of training and experience performing roles for which they are competent. Community pharmacists will also be responsible for more clinical care within the networks, eg through the community pharmacy consultation service for minor ailments.<sup>10</sup> There will also be new roles for pharmacy technicians in PCNs, and specialist pharmacists (eg from hospitals) are likely to be running clinics in a primary care setting and providing professional support to colleagues.

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## Declaration of interests

Duncan Petty provides advice to McKessons UK on primary care pharmacy. He is a member of the RPS English National Pharmacy Board. The views expressed here are his own and do not necessarily reflect those of the RPS.

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