Life & Times

Clinical pharmacists in general practice:

a necessity not a luxury?

THE SCALE OF THE PROBLEM

Having a clinical pharmacist in the primary healthcare team is a 'no brainer'. Prof. Avery[1] suggests that any GP, and indeed patients, who have benefited from a clinical pharmacist working in their practice would never choose to be without their medicines expert. Take a look at the numbers. A practice serving a patient population of around 30 000 patients can expect to issue half a million prescriptions a year. They will have 1000 patients on more than eight medicines,[2] there is a potential prescription error rate of 5%,[3] and they might reasonably expect around 300 medication-related non-elective hospital admissions.[4]

However, as Prof. Avery alludes to, the payment model in general practice does not currently place any value on the quality and safety aspects of medicines usage. He also throws down the gauntlet, questioning why partners would therefore choose to pay these experts to improve the quality of medicines use unless they could also reduce their workload.

METRICS

Since the NHS England pilot scheme for clinical pharmacists started last year, Westbourne Medical Centre has been very aware of the need to prove the worth of clinical pharmacists and has been collecting both process and patient outcome measures. They record all pharmacist activities that directly relate to patients (telephone consultations, face-to-face consultations for patients with polypharmacy, prescription queries, clinical tasks from clinicians, and medicines reconciliations post-hospital discharge) using a template on the practice software.

We believe metrics to assess all changes in general practice need to be relevant, objective, and easy to collect. Templates that record such workload data may well be the answer to gauging if clinical pharmacists are worth it. We agreed an average time needed to perform such activities, which otherwise would have been done by a GP, and have estimated that one post saves GPs 80 hours a month (excluding indirect patient activities). Identifying outcome measures has been much more challenging. In the absence of any other reliably sensitive and specific quality measures, we are using the new national medicines optimisation polypharmacy comparators[2] as we share the views of Swinglehurst and Fudge[5] that

> "[Clinical pharmacists] *should be viewed as collision-avoidance technology …*"

problematic polypharmacy is a 'wicked problem'[6] at the heart of medicines usage in patients with multimorbidity.

The comparators can be successfully used as a risk stratification tool to help practices decide which patients need a thorough medication review. For example, they can identify patients on more than 10 or 15 medicines as well as those on high-risk combinations (*BNF*, chapters 1–4 and 6–10), which are most likely to cause preventable hospital admissions (triple antithrombotics or NSAIDs and 'DAMN' drugs).

MEDICATION REVIEWS

The subtlety and complexity of medicines and the increasing amount of NICE-endorsed and hospital specialist 'silo prescribing' means that medication review by medicines experts in primary care is now essential. However, this type of work is currently difficult to achieve in general practice due to a lack of dedicated time and appropriate specialist skills. We believe such complex medication reviews should be the focus of practice-based clinical pharmacists, and can be done at the same time as QOF recalls, avoiding duplication of effort.

The cooperation and learning that occurs with clinical pharmacists also helps GPs' responsibility to improve their professional development. This increasingly involves not just learning competencies, but also developing personal capability[7] to deliver optimal patient care within inevitable working constraints.

The polypharmacy editorial[5] reminded us that it was inevitable that medicine would always collide with age. Clinical pharmacists are neither cheap doctors nor expensive nurses but can be harnessed as part of the primary care team to ensure that patients with chronic diseases do not become acutely unwell due to preventable adverse effects of unnecessary, or non-adherence to, medicines. They should be viewed as collision-avoidance technology, preventing collisions, rather than positioned as airbags designed to minimise injury once the collision has occurred. Whoever foots the bill, we believe that clinical pharmacists in general practice in this world of problematic polypharmacy, overdiagnosis, and medicalisation are here to stay and are a necessity, not a luxury.

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REFERENCES

1. Avery AJ. Pharmacists working in general practice: can they help tackle the current workload crisis? *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp17X692201.
2. NHS Business Service Authority. Medicines optimisation: polypharmacy. 2017. https://www.nhsbsa.nhs.uk/prescription-data/medicines-optimisation-polypharmacy (accessed 30 Nov 2017).
3. Avery T, Barber N, Ghaleb M, *et al. Investigating the prevalence and causes of prescribing errors in general practice: the PRACtICe Study (PRevalence And Causes of prescrIbing errors in general practiCe).* London: General Medical Council, 2012.
4. NHS England. *Medication safety in the NHS.* 2015. http://www.improvementacademy.org/documents/Projects/medicines_safety/Medication%20safety%20in%20the%20NHS%20infographic%20faults%20and%20remedies%20NHSE%20March%2015.pdf (accessed 30 Nov 2017).
5. Swinglehurst D, Fudge N. The polypharmacy challenge: time for a new script? *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp17X692189.
6. Grint K. Problems, problems, problems: the social construction of 'leadership'. *Hum Relat* 2005; **58(11):** 1467–1494.
7. Fraser SW, Greenhalgh T. Coping with complexity: educating for capability. *BMJ* 2001; **323(7316):** 799–803.