

A pharmacy workforce survey in the West Midlands: (3) Primary care pharmacists

By Alison Blenkinsopp, PhD, MRPharmS, Helen Boardman, BSc, MRPharmS,
Jill Jesson, PhD, and Keith Wilson, PhD, MRPharmS

AIM • To quantify the extent of current and planned employment of primary care pharmacists (PCPs) and to explore the experiences of PCPs and the perceptions of other pharmacists who aspire to become PCPs.

DESIGN • Pre-piloted postal questionnaire containing open and closed questions and semistructured telephone interview with a subsample of pharmacists.

SUBJECTS AND SETTING • All registered pharmacists aged up to 65 years, together with those aged over 65 and still working, in the West Midlands region. Telephone interviews were with respondents in specific groups — recently qualified, career break, “career” locums, those working as or wanting to work as a PCP.

RESULTS • At the beginning of 1997, 66 pharmacists were working as PCPs, an increase from 16 in 1995. PCPs provide services for 8% of GP practices in the West Midlands. A further 30 pharmacists reported that

they were due to start work as a PCP in 1997. Almost all PCPs worked part-time, with one session per week (equivalent to a half day) being the median commitment. Overall one in three pharmacists expressed interest in working with GPs. Interest in training programmes to prepare for this type of work was high. Data from the telephone interviews suggest two main perceived models of working: reactive (pharmacy-based) and proactive (GP practice-based). PCPs expressed a high level of satisfaction with their work. Pharmacists who wished to become PCPs were generally passive in this respect and few had made active moves to find such work.

CONCLUSION • The satisfaction experienced by primary care pharmacists appears to offset to some extent the dissatisfaction expressed about traditional pharmacy work in community pharmacy. The high level of interest in PCP work may also be a proxy for pharmacists' dissatisfaction.

Prescribing by general practitioners (GPs) in primary care has come under increased scrutiny in recent years in the United Kingdom. Cost and content of prescribing are routinely monitored by local health authorities. Research has shown that GPs recognise the pressures that are contributing to prescribing patterns and are taking action to make changes.^{1,2} This climate of concern about prescribing has been the catalyst for the development of a new occupational group within the profession of pharmacy, known as primary care pharmacists (PCPs). We would define a PCP as “a pharmacist who works with primary care physicians and patients to enhance the quality of prescribing and use of medicines, and to contribute to resource management of medicines”.

During the early 1990s, a small number of health authorities pioneered schemes where local community pharmacists were contracted to work on a sessional basis for one or more medical practices in primary care. These early efforts were recognised and strengthened by the availability, from 1996, of funding from GPs' prescribing budgets to purchase prescribing advice. Health authority pharmaceutical advisers then played a key role in supporting and de-

veloping PCP schemes locally, and geographical differences are apparent at local, regional and national level. Some 30 health authorities in England facilitated local arrangements for the employment of PCPs and further underpinned the spread of the new role.³ A Department of Health initiative supported 16 pilot projects on prescribing advice in primary care between 1994 and 1996. The emerging findings from these projects contributed to the understanding of the potential of PCPs.^{3,4}

Despite this expansion of activity, there is little published research about PCPs. A conceptual model of PCPs, together with their profiles and activities, has been reported.^{5,6} There is some evidence of the effec-

tiveness of PCPs in containing prescribing costs⁷ and of pharmacist-conducted medication review.^{8,9} However, there are no published studies on workforce planning aspects, for example, the numbers of PCPs employed, their patterns of work, or satisfaction with the work. Nor have any previous studies considered the level of interest in such work among the general population of pharmacists. The aims of this study were, for one English region, to:

- to quantify the extent of current and planned employment of primary care pharmacists
- to describe the background and previous work experience of such pharmacists
- to explore the experiences of pharmacists undertaking such roles, with particular emphasis on job satisfaction
- to investigate the perceptions of pharmacists who aspire to work as a PCP
- to explore the potential effects of the development of PCPs on the pharmacy workforce

METHOD

The research employed a two-stage methodological approach. Data were obtained from two main sources. The first

Professor Blenkinsopp is professor of the practice of pharmacy, and Ms Boardman is research assistant in the department of medicines management, Keele University. Dr Jesson is lecturer in public services management, Aston Business School and Dr Wilson is head of the pharmacy practice group in the department of pharmaceutical sciences, Aston University. Correspondence to Professor Alison Blenkinsopp, Department of Medicines Management, Keele University, Keele, Staffordshire ST5 5BG (e-mail a.blenkinsopp@keele.ac.uk)

source of data was answers to a pre-piloted postal questionnaire sent to 2,568 registered pharmacists in the West Midlands region of England in late 1996 with a follow-up mailing early in 1997. The sample, obtained from the Royal Pharmaceutical Society's register database, included all registered pharmacists up to age 65 plus all those over 65 whose registration code indicated that they were still working. The detailed methods, including questionnaire development, response validation and analysis, have been published previously.^{10,11} Respondents were asked to specify their employment in different sectors of the profession, including weekly hours worked in each, for the years 1995, 1996 and 1997. The questionnaire also asked pharmacists their level of interest in working in different sectors of the profession. One of the categories was "work with GP practice(s)" which was, at the time of the study (before the introduction of primary care groups and primary care trusts) the model for PCPs. The questionnaire also assessed level of interest in different post-graduate educational paths, including programmes to prepare for work with GP practices. Pharmacists were also invited to take part in a follow-up interview, in which case they were asked to provide contact details.

The other source of data was semi-structured telephone interviews conducted with a subsample of 80 respondents. The purpose of the sampling was to produce the following subgroups:

- Those newly or recently qualified (within the past five years (n=20))
- "Career" locums (n=20)
- Those taking a career break or wishing to leave the profession (n=20)
- Those currently (n=10) or aspiring to be (n=10) a PCP

The findings from the fourth group of 20 interviews are reported here. Interview schedules were developed by the researchers with input from a "user group" of practising pharmacists. The schedules contained core questions plus specific questions for each sub-group. Initial contact was made with each pharmacist by telephone and an appointment was made for a subsequent call for the interview. The interviews were audiotaped with the respondents' permission and were then transcribed, and themes identified, grouped and coded.

RESULTS

The questionnaire achieved a response rate of 68.8 per cent (1,767) after one reminder. The demographic profiles of the 20 interviewees working as, or expressing interest in working as, a primary care pharmacist are shown in Table 1 and reflect the pattern of questionnaire respondents working or wanting to work with GP practices. Such pharmacists were younger and more likely to be female.

Profile of primary care pharmacists The survey showed that the numbers of pharma-

TABLE 1: DEMOGRAPHIC PROFILE OF INTERVIEWEES (N=20)

Variable	Working as PCP?	
	Yes	No, but interested
<i>Branch of pharmacy</i>		
Community	7	7
Hospital	0	2
GP practice	1	0
Academic	1	0
Other	1	1
<i>Years registered as a pharmacist</i>		
0-10	5	7
11-20	5	3
21 and over	0	0
<i>Age</i>		
21-30	2	6
31-40	7	3
41-50	1	1
51 and over	0	0
<i>Gender</i>		
Male	3	3
Female	7	7
<i>Ethnic group</i>		
White	9	5
Non-white	1	5
<i>Weekly hours worked in pharmacy</i>		
10-19	1	0
20-29	1	0
30-39	2	4
40-49	4	4
50-59	2	2
<i>Weekly hours worked with GP practice(s)</i>		
None	0	0
1-4	4	0
5-8	3	0
9-12	0	0
13-16	1	0
17 and over	2	0

cists working as PCPs in the West Midlands had increased from 16 in 1995 to 66 by the end of 1996. A further 30 pharmacists were due to start work as PCPs in 1997, bringing the total to 96.

The majority of pharmacists working as PCPs (98 per cent) worked part-time, most of these (82 per cent) working eight hours or less per week. Two thirds of PCPs were aged under 40 years, whereas in the overall sample the percentage in this age band was around half. Almost 60 per cent of PCPs were female, compared with a figure of 53 per cent for the overall sample. Most PCPs (70 per cent) were based in community pharmacy, a figure similar to that for the total sample.

Pharmacists already working as PCPs Most of the interviewees worked fewer than two sessions (eight hours) a week with their practices and indicated that most of their efforts so far had been devoted to reviewing and enhancing repeat prescribing management:

"I go to a GP practice one afternoon a week. It's looking at repeat prescribing and PACT data. The ways they can improve their repeat prescribing." (138)

"I work for one practice regularly half a day a week. A lot of it has been in the production of a repeat prescribing policy, which has taken over a year to develop." (147)

"I'll do a general overview of their prescribing and then we can pick out areas of interest to them" (168).

Some of the PCPs were involved in other areas of work:

"The mainstay of my regular work [now] is looking at hospital discharge notes on a week-to-week basis and making sure what's on the computer is correct." (147)

The PCPs' accounts indicated a hierarchy of tasks, beginning with assessment of prescribing analysis and cost (PACT) data and repeat prescribing systems, with a move to more complex and clinical work over time. All the interviewees had completed additional training before taking up their work with GP practices and felt this was important:

"Talking personally . . . I really needed to look at the therapeutic groups in a lot more detail . . . training in literature searching and accessing medical information in all the therapeutic groups." (157)

"I think we are moving towards a situation where for standards' sake we ought to be saying that pharmacists should have a further education diploma of some sort . . . to make sure that standards are maintained." (147)

"It's something we need to be aware of . . . to make sure your clinical background is kept up to date." (122)

Clinical knowledge was thus seen as key to success in the PCP role. One of the interviewees reported that the practices were aware of this:

"On the initial visit to one of the practices my qualifications to do that type of work were questioned by the lead GP." (151)

Communication skills were cited by only one of the pharmacists as crucial:

"The other important factor . . . is communication. I have seen a lot of capable pharmacists — in terms of clinical expertise — but when they actually come to put it across it doesn't happen." (122)

None of the PCPs was involved in working directly with patients at the practice; their roles mainly related to paper-based reviews and recommendations to the GPs.

The interview data showed that pharmacists involved in PCP work reported fulfilment of their positive expectations of the work. A key theme was the pharmacists' perception of enhanced standing in the eyes of GPs and other practice staff and this was interwoven with reduced feelings of professional isolation:

"I like [the] appreciation. GPs know that you are a professional and are working for the benefit of the patients." (160)

"The interaction with the GPs, the practice nurses and feeling far more integrated into the health care planning . . ." (151)

"Working with different people and it's improving peoples' impression of pharmacists . . ." (138)

Primary care pharmacists found their work professionally satisfying and their accounts showed how both intellectual engagement and perceptions of a deeper involvement in medication decisions contributed to this satisfaction:

"We are doing more than getting involved in the supply process. . . . I am obviously getting involved in medication decisions." (157)

"More variation . . . using my knowledge as opposed to just working in a shop . . ." (138)

"It's giving me opportunity to use my brain." (160)

"Using different knowledge than we do everyday in our practices . . ." (151)

Where the community pharmacist PCP was local to the practice, benefits to their everyday work were also evident:

"I had more contact with the receptionist than anybody else at the practice (before working there) so it's improving the relationship with them as well." (138)

"It's a natural progression for us — we have got a health centre branch — and the doctors are very receptive because they know us." (157)

There was only one indication of frustration where the agenda was perceived by the pharmacist to be restricted by the doctors in the practice:

"As soon as I started looking at real prescribing issues, as in why they were prescribing certain classes of medicines, they said that was their choice and they didn't want me for that. . . . All they wanted me to do was tell them what they could be prescribing cheaper." (152)

Interest in and perceptions of working as a PCP Almost one third of survey respondents (31.6 per cent) expressed interest in working with a GP practice; 70 per cent of these were aged under 40. Most (81.4 per cent) were working in community pharmacy and pharmacists working for large multiples were the keenest to become involved in PCP work. The interviews showed that pharmacists had different perceptions of working with GP practices. Three of the 10 interviewees perceived the role as based in community pharmacy but with greater contact with local GPs. We termed this the "reactive" model since pharmacists' accounts envisaged responding to GPs' queries about treatment and being passive recipients of more information from GPs about patients:

"It would be useful to establish good links with local GPs nearby and get to know them on a name basis . . . so they can ask you any queries they've got with drugs and medication." (113)

"I think on one level it would be communication for when their patients are admitted and discharged." (156)

The remaining seven interviewees perceived the role as based in the GP practice setting. We termed this the "proactive" model as pharmacists' statements described intervening in decisions about prescribing and involvement in medicines policy-making at practice level:

"Prescribing advice, diabetic clinics, that sort of thing." (112)

"Look at the repeat prescriptions and try to help the surgery with the repeats." (123)

The accounts of these pharmacists indicated that they felt professionally undervalued and saw PCP work as a means of increasing both professional status and job satisfaction:

"[GPs] are the key health care professional both to enhance our status and to gain closer links with patients." (125)

An underlying theme was the desire to be more involved in medication decisions at an earlier stage in the process:

"Being more involved higher up the chain in the supply of medicines rather than just dishing them out . . . actually being able to influence what people are prescribed and how well they make the most of their medicines." (112)

Evidence to support this assertion comes from the questionnaire, where most respondents (60 per cent) expressed a wish to work more closely with other health professionals and younger and female pharmacists were keenest to do so.^{10,11}

Despite interviewees' professed interest in working with GP practices there was little indication from the interview transcripts of intent or concrete action being taken by these pharmacists to obtain work as a PCP.

"I've thought about it . . . thought about doing the clinical diploma to get more experience." (113)

"When I worked as a manager at [a multiple] there were a few job openings on that side where you could be involved in [GP practice work]." (117)

"I'm sure my boss wouldn't like it if I said I want to spend a couple of afternoons a week working with GPs." (156)

This reticence to be proactive in seeking work was echoed in the comments of one of the pharmacists already working as a PCP:

"Not to talk about it but to make an approach. I think most pharmacists are waiting for someone

to make the approach for them and that's not going to happen, at least not in my experience." (157)

DISCUSSION

The number of PCPs increased six-fold over a three-year period and interest in PCP work was high among other pharmacists. One of the strengths of the study was its bringing together of quantitative data with qualitative work to provide a deeper understanding of the underlying issues. Collection of data relating to a three-year retrospective period together with information about future work allowed us to obtain a fuller picture than would have been possible from a single point in time. The research was conducted before the formation of PCGs and PCTs but nevertheless provides relevant information about practice level PCP work. It is not the intention of a qualitative enquiry to produce findings that are generalisable to the total population but rather to provide insights into participants' views, experiences and reasons. Here the qualitative data shed further light on pharmacists' perceptions and motivations in relation to PCP work and how it relates to their existing professional life.

Our finding that pharmacists had different interpretations of what PCP work might involve might be due to the wording of the survey question and a lack of clarity that we meant work based outside the pharmacy. Thus the responses may overestimate the proportion of pharmacists who wish to undertake such work.

The implications of the expansion of primary care pharmacy for the pharmacy workforce are significant. During the period of the study there was little change in the pattern of hours worked, with most being employed for one or two half day sessions per week. The workforce implications of further spread of these part-time practice level posts, with incumbents drawn mainly from the community sector, are potentially substantial. On the other hand, it could be argued that the increased job satisfaction from such work might lead to greater retention of pharmacists within the community sector at a time when employers have reported difficulties in recruitment.

More recently, the development of primary care groups in England since 1999 and primary care trusts since 2000 has led to a large increase in the number of more substantive pharmacist posts, many on a full-time basis and with a strategic focus. Anecdotal reports suggest that many of these posts have been filled by pharmacists from health authority or hospital backgrounds. The extent to which these new posts are in addition to, or instead of, existing practice level posts is not yet known. Other research on PCPs did not show hospital pharmacists taking up practice-based roles to any great extent.¹² However, the higher level strategic posts offered by PCGs and PCTs may have proved more attractive. The workforce implications of substantive pharmacist posts given the 400 PCGs in England are potentially large, both in terms

of numbers of whole time equivalents required and training and development needs. The effects of the transition from PCGs to PCTs on demand for pharmacists are as yet unclear.

Although we did not use a formal measure of job satisfaction, the accounts of pharmacists working as PCPs demonstrated high levels of satisfaction with their work. The closer relationships with GPs and other practice staff brought a new dimension to the work of community pharmacists and appeared to increase satisfaction in community pharmacy work also. Community pharmacists working as PCPs described how their knowledge and skills were being better used, the implication being that this applied in both settings. Further work would be needed to investigate whether the level of patient care provided by community pharmacists who also worked as PCPs was in fact different from those who did not.

Interest in working as a PCP was highest among younger pharmacists. The finding that pharmacists from large multiples were the keenest to become PCPs is likely to be at least partly explained by the age profile, since multiples have a higher number of

young pharmacists than do independents.^{10,11} Employer encouragement to develop new services and roles may also play a part. Multiples might make different demands on employee pharmacists than employers in the independent sector.

There was little evidence that pharmacists reporting a desire to work as a PCP had made attempts to secure such work, or that they had active plans to do so. This could be explained by lack of overt opportunities in particular localities. However, it is also possible that expressed interest in PCP work is a proxy for job dissatisfaction in community pharmacy and reflects community pharmacists' desire for greater professional recognition and closer working with other health professionals rather than an intent to pursue such posts. Our findings also show that pharmacists want to make greater use of their knowledge and skills, and that they find little professional challenge in dispensing. That many community pharmacists tend to be reactive rather than proactive¹³ may also play a part here.

The NHS plan for England sets out a target that by 2004 all PCGs and PCTs should have arrangements in place to use

pharmacists' skills to help patients to get more benefit from their medicines. An action team on medicines management will identify and disseminate good practice exemplars. Further research is needed to track the development of PCG and PCT pharmacist policies and posts, activity profiles and emerging issues.

CONCLUSION

Demand for pharmacists to work with GP practices and groups of practices has increased substantially since 1995. Primary care pharmacists find a high level of satisfaction in their work and believe that it uses their skills profile appropriately. There is a high expressed interest in PCP work among the general population of pharmacists. To some extent this interest appears to spring from dissatisfaction with current community pharmacy work, a desire for closer working with other health professionals and to make better use of their skills and knowledge.

Further research is needed to underpin the future development of primary care pharmacy practice.

REFERENCES

1. Cantrill JA, Dowell J, Roland MO. Qualitative insights into general practitioners' views on the appropriateness of their long term prescribing. *Int J Pharm Pract* 2000;8:20-6.
2. Russell D, Luthra M, Plastow L, Airdrie R, Marshall M. Cost-effective prescribing in general practice: patients' attitudes to financially motivated prescribing changes. *Int J Pharm Pract* 2000;8:27-32.
3. National Prescribing Centre. Prescribing support in primary care. Liverpool: NPC; 1999.
4. Goldstein R, Hulme H, Willits J. Reviewing repeat prescribing — general practitioners and community pharmacists working together. *Int J Pharm Pract* 1998;6:60-6.
5. Jesson JK, Wilson KA. Primary care pharmacists: a conceptual model. *Pharm J* 1999;263:62-4.
6. Martin RM, Lunec SG, Rink E. UK postal survey of pharmacists working with general practices on prescribing issues: characteristics, roles and working arrangements. *Int J Pharm Pract* 1998;6:133-9.
7. Rodgers S, Avery AJ, Meechan D, Briant S, Geraghty M, Doran K et al. Controlled trial of pharmacist intervention in general practice: effect on costs. *Br J Gen Pract* 1999;49:717-20.
8. Mackie CA, Lawson DH, Campbell A, Maclaren AG, Waigh R. A randomised controlled trial of medication review in patients receiving polypharmacy in general practice. *Pharm J* 1999;263(Suppl):R7.
9. Granas A, Bates I. The effect of pharmaceutical review of repeat prescriptions in general practice. *Int J Pharm Pract* 1999;7:264-75.
10. Blenkinsopp A, Boardman H, Jesson JK, Wilson KA. A pharmacy workforce survey in the West Midlands: (1) Current work profiles and patterns. *Pharm J* 1999;263:909-13.
11. Boardman H, Blenkinsopp A, Jesson JK, Wilson KA. A pharmacy workforce survey in the West Midlands: (2) Changes made and planned for the future. *Pharm J* 2000;264:105-8.
12. Wilson KA, Jesson JK, Blenkinsopp A. The training needs of primary care pharmacists: a report to the NHS Executive West Midlands. Birmingham: Aston University; 2000.
13. Tann J, Blenkinsopp A, Allen J, Platts A. Leading edge pharmacists. *Int J Pharm Pract* 1996;4:235-45.

COMMONWEALTH PHARMACY DAY: JUNE 16

June 16 has been designated Commonwealth Pharmacy Day, when pharmacists in Commonwealth countries are asked to make a special effort to promote the profession. June 16 was chosen because it marks the date of the inaugural meeting in 1969 which led to the formation of the Commonwealth Pharmaceutical Association. (It is also the birthday of one of the CPA's principal founders, the late Albert Howells, OBE, who chaired the inaugural meeting.) Celebrated since 1982, Commonwealth Pharmacy Day is used annually in some countries to promote pharmacy to other health professions, to government departments and to the public.

Since its foundation, the Commonwealth Pharmaceutical Association has been strongly supported by the Royal Pharmaceutical Society, which provides the association's secretariat. British pharmacists can become personal members of the CPA for an annual fee of £10. Applications for membership should be sent to the Secretary, Commonwealth Pharmaceutical Association, 1 Lambeth High Street, London SE1 7JN.

ARE YOU MISSING OUT?

If your current employment category is not recorded on the Royal Pharmaceutical Society's computer you could be missing out on mailings and *Journal* supplements relevant to your area of practice.

You can give the necessary information by filling in the appropriate part of the annual retention fee form. If you have failed to do this, or if you have since changed your career, you can write, giving your principal employment category, to Law Records, Royal Pharmaceutical Society, 1 Lambeth High Street, London SE1 7JN.