

EVALUATION OF A practice pharmacist SCHEME

The views of general practitioners on the usefulness of having a pharmacist working within practices are explored in this article

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The organisation of medical care within England and Wales has undergone radical changes in the past few years. Pharmacist involvement in providing advice on prescribing in primary care has been encouraged by both the Government¹ and the pharmaceutical profession.² A recent study³ showed that around 40 per cent of general practices receive advice from pharmaceutical advisers, although the extent of that advice is not known.

South Cheshire health authority (HA)

appreciated the value of collaboration between community pharmacists and general practitioners on prescribing issues and identified a number of areas where improvements could be made. These included formulary development and implementation,⁴ rationalising prescribing, auditing repeat prescribing, extending generic prescribing, and improving patient communication and education.

A number of fundholding practices had employed pharmacists on a sessional basis to assist with the management of prescribing resources. The success of this initiative prompted South Cheshire HA to establish a similar scheme for non-fundholding practices. The HA then decided that the effectiveness of this collaboration should be monitored and evaluated. As a result, it asked us to conduct an independent study to evaluate general practitioners' views on a health authority-funded practice pharmacist scheme.

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All community pharmacists and non-fundholding general practices in South Cheshire were sent information on the proposed scheme, including background information, how to register and the criteria that had to be fulfilled in order to be accepted. The level of funding was sufficient to reimburse pharmacists for working one full day per week for six months or one half-day per week for 12 months. Criteria for acceptance on the scheme included setting three objectives for each pharmacist. The objectives set by the practices were broadly

categorised according to Table 1. A quarterly summary of progress was required by the HA, satisfactory submission of which triggered reimbursement.

Participating pharmacists were given advice and support from the HA's pharmaceutical advisers who provide prescribing advice to practices within the authority. A practice pharmacists' support group was set up, providing information on documentation and reports published by the NHS and the South Cheshire HA.

The first pharmacists began working with the GP practices that had been accepted on to the scheme in September, 1997. The number of partners within the practices ranged from one to six, and two of the six participating practices were dispensing practices. At the time of the evaluation (July, 1998) 11 pharmacists had become involved. Four of the 11 were already known to the practices. Two pharmacists worked in a pharmacy within or next to the practice.

The pharmacists included some working in community either full- or part-time and one had a hospital background. Three pharmacists had undertaken a training course on interpreting prescribing analyses and cost (PACT) data. One had completed a postgraduate diploma in community pharmacy and, at the time of the study, another was undertaking the same diploma on a part-time basis. One pharmacist worked on a one-day per week basis with the remainder on a half day per week, as a single or split session.

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The perceptions of the general practitioners (GPs) were sought using a specially developed semi-structured questionnaire.⁵ Background information on the development and implementation of the scheme (personal communication) was scrutinised by the researchers and the major areas for exploration were identified. The researchers and HA discussed these areas before finalising the project. The questionnaire was piloted at a fundholding practice, where a pharmacist had been providing prescribing advice for over 12 months, and some changes were made following this. The questions were divided into six sections:

- Initiation of the project
- Setting of objectives
- Operation of the system
- Meeting the objectives
- Outcomes of the scheme
- The future

Letters were sent by the HA to all practices informing them that the evaluation was being conducted. This was followed by telephone calls from the researchers asking for agreement to participate and to arrange a convenient appointment time for the interview. All selected practices agreed to participate in the evaluation.

Interviews were conducted within the practices. Two researchers, trained in interview technique, conducted the interviews. Each interview was recorded on audiotape with the agreement of the interviewees and was subsequently transcribed. Transcripts were evaluated independently by the two researchers before joint analysis.

Nine GPs from six practices involved in the scheme, were interviewed using the semi-structured questionnaire.⁶ In three practices, a liaison GP for the project was interviewed. In the other three, two GPs were responsible for liaison with the practice pharmacist, so both were interviewed.

Following evaluation, a full report of the study and its findings was sent to the HA and to each participating practice. The

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Table 1 Categorisation of objectives set by participating practices

Objective category	Frequency
Review of prescribing for a specific disease/therapy group of patients	12
Review of repeat prescribing	6
Production of a formulary	5
Monitoring therapeutic guidelines	4
Increasing generic prescribing in specific therapeutic areas	2
Reducing inappropriate polypharmacy	2
Demonstrating validity of Prescription Pricing Authority prescribing data	1
Review of nursing home prescribing	1
Total	33

researchers received no comments concerning the accuracy of the data.

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Results are presented under the headings used in the questionnaire, along with some verbatim comments from interviewees to illustrate the context of the analysis.

Initiation of the project

What was your initial response to the approach from the HA?

Four of the practices were immediately enthusiastic about entering the scheme. The other two were more cautious but agreed to try it as an experiment, despite the unfounded fear, expressed by one GP, that the HA was using the pharmacist to check up on the practice. In addition, two practices said that the scheme was opportune, as they had been discussing ideas about improving prescribing.

GP 5 "Enthusiastic, I would say. We had quite a few areas that we were starting to think about looking at ourselves, so it probably tied in quite well."

Why did you decide to enter the scheme?

For four of the practices, the possibility of cost saving, usually highlighted from PACT data, was the main reason for entering the scheme. Two practices were aware that they needed to increase their level of generic prescribing. Two practices also said that it

would be useful to have advice from another professional with relevant expertise.

GP 7 "I was quite horrified to discover that we were the second highest prescriber of non-steroidal gels in the HA. That was probably the biggest precipitating factor that made me say we could probably do with professional advice."

How was the pharmacist allocated to your practice?

In two cases, the pharmacist was known to the practice as a result of working in an adjacent pharmacy. In one case, the pharmacist was known socially by one of the partners. In another, the name of the pharmacist was recognised by one of the partners from previous employment in a different location. In two cases, the pharmacist was a complete stranger to the practice. Some practices preferred a local pharmacist, while others requested a pharmacist without a local interest.

GPs were asked whether they had any concerns about a potential conflict between their requirements and the commercial interests of the pharmacist but none saw this as a problem. Ultimately, the quality of the professional relationship that evolved seems to have mattered more than whether the pharmacist was local or not.

Setting of objectives

Who decided on the objectives?

Respondents were aware of their practice's

objectives. The HA's objectives were acceptable to the practices as, in many cases, they were in line with their own future plans. In three practices, the partners had decided on the objectives before discussing their ideas with the practice pharmacist. In the other three practices, joint discussions took place.

Why were the particular objectives chosen?

Cost savings and rational prescribing were the main reasons cited.

The introduction of the pharmacist scheme appears to have given the impetus for the practices to make improvements to prescribing through closer analysis of PACT data and the introduction of practice guidelines.

GP 7 "PACT data more than anything else. A thing which has been very useful was I said I didn't believe my PACT data — I was most surprised when she proved it was correct."

GP 9 "We were looking as well at some of the prescribing issues being a step towards the practice's development of guidelines for chronic disease management."

Operation of the system

How much time did the pharmacist need to become familiar with the operation of the practice?

In all practices, the pharmacist needed no more than one (approximately four-hour) session to become familiar with the practice. This was mainly to learn how the computer system worked.

At the start of the scheme, did you perceive any deficiencies in the pharmacist's pharmaceutical knowledge, communication skills or keyboard skills? The practices did not mention any deficiencies and additional skills were highlighted.

GP 9 "We also found we liked the way she interacted with the partners. She would aid focusing of discussion in our lunch time meetings. She was quite firm in discussing things. She wasn't

easily derailed by us talking about other things."

The GPs did not mention that they had noticed a difference in the level of knowledge and skills of pharmacists who had undertaken postgraduate training and those who had not undertaken such training.

How frequently does the pharmacist visit the surgery?

Some GPs did not know when the pharmacist visited the practice, apart from the times when they provided feedback to the partners. Feedback sessions were generally irregular and ad hoc, primarily because it was difficult to find times when all partners and the pharmacist were available. Other constraints included a lack of availability of rooms and computer terminals. In two practices, pharmacists did not have direct access to patient medical records without supervision by practice personnel.

What does the pharmacist do when visiting the practice?

In addition to work associated with the objectives, the pharmacist frequently provided additional advice. Having a pharmacist available to answer questions of a pharmaceutical nature was commented upon favourably by one practice.

GP 9 "We tend to see drug reps three lunchtimes during the week; so when the pharmacist is around she comes up to discuss things with us and sees the drug reps at the same time. Its quite nice to have a pharmacist around when the reps are telling us the wonders of their new drugs. They tend to be more knowledgeable and critical."

Half the practices said that the pharmacist was involved in counselling patients.

GP 8 "Yes. She has helped them a lot, like asthma or high blood pressure, she goes to those clinics. She talks to the patients about medication, how to use their drugs."

In what way does the pharmacist work with other members of the practice?

The pharmacists appear to have integrated well with all members of the practice team.

They developed relationships with the practice manager in four of the practices and with practice nurses in three.

What sort of feedback does the pharmacist provide to the practice?

In all practices, the pharmacist provided written and verbal reports. These were variable in their frequency, length and content.

Have there been any comments from patients regarding the pharmacist?

Pharmacists were involved directly with patients in three of the practices. No specific comments from patients were made at two but favourable comments came from the third.

Where the pharmacist has made recommendations regarding changes to patients' medication, have these been acceptable to the GPs in the practice?

All practices agreed that the recommendations were generally acceptable; however, not all of them were acted upon.

GP 3 "When she makes a recommendation, we normally discuss it and when we have agreed a plan of action we then go on and implement it."

Meeting the objectives

To what extent have your objectives been met?

All practices considered that they were meeting their objectives. In practices where the pharmacist had been in post since the inception of the scheme many of the original objectives had been met and new ones had been set. Different perspectives on the longer-term strategy were illustrated by comments from two of the respondents.

GP 7 "Of course the first objectives are always, in a sense, the easiest because it is the biggest problems you tackle first. So there will always be a law of diminishing returns with this sort of programme."

GP 9 "Time will tell. I think that the initial review of figures is quite good but you just wonder whether you've got to keep revisiting these things to avoid

slipping back into the old ways of initiating drugs, let alone reviewing them."

Outcomes of the scheme

Where do you think that the pharmacist has made the greatest contribution?

Responses tended to be non-specific, concentrating on the general benefits of having a knowledgeable professional within the practice.

GP 2 *"I think it has helped to have a more scientific approach."*

GP 5 *"To me the important thing is focusing on good intentions. We are full of good intentions but we do not actually always get round to addressing them, whereas the fact that we have got to meet with her regularly and discuss them means that we actually have something to show her."*

Has the initiative affected discussions between partners, on prescribing issues?
All practices expressed the view that the pharmacist's involvement had affected discussions between partners on prescribing.

GP 1 *"I think that the first thing that I did after discussing lipid lowering drugs, was to actually audit a group of patients to see who had had their cholesterol checked. It was looking at our standards in the practice which stemmed from a pharmaceutical discussion about choosing lipid lowering drugs."*

To what extent did the practice analyse PACT data before the pharmacist became involved?

PACT data did not appear to have been looked at seriously by the practices prior to the scheme.

GP 3 *"Well we always used to read it and file it. If you are around average, you tend to think, oh well, we are probably getting it about right, and carry on."*

Has the extent of PACT data analysis changed as a result of the scheme?

Respondents frequently referred to PACT analysis. However, data analysis was used more extensively by the pharmacists than by

the GPs.

Do you think that any pharmacist could fulfill this role?

In general, most practices considered that any pharmacist could carry out the same function.

GP 7 *"I think a lot of what has been done has depended on interpersonal communication, selling skills. In an ideal world all pharmacists ought to have those, but probably, like all doctors, they don't."*

Do you think that the pharmacist's work has resulted in any increase or decrease in costs to the practice?

General perceptions were that costs may have gone down but little firm evidence was cited.

GP 1 *"Looking globally at the whole formulary, I don't think it has changed radically but small areas such as antibiotics would go down but that is going to be outweighed by other things going up, like atypical antipsychotics, which have vastly changed."*

GP 3 *"I would have thought that her work is actually producing savings at the moment in terms of reduction in the way the budget has been spent."*

GP 9 *"Perhaps not directly, but we're aware there are going to be increases in costs through innovations such as lipid treatment. We're hoping that some of the rational prescribing will reduce costs in the long-term."*

Do you think that the objectives achieved by the scheme justify the cost to the HA for employing the pharmacist?

There were varying degrees of conviction as to the extent of the justification but all practices considered that the cost was worthwhile.

GP 2 *"I have no idea what the cost is. My impression would be, yes. Well, it is actually more than just the cost. Any form of increase in knowledge is worth it."*

GP 6 *"I suspect that the thing we are doing is actually patting ourselves on the back and saying 'Gosh, haven't we done well'. For us it's great and it's an opportunity for us to focus our minds and do things we want to do, which I am sure in the long-term will have knock-on effects for prescribing. It might make us better prescribers."*

GP 7 *"I would say, absolutely, more than justified. I'm absolutely sure you could go to any practice in the country and find things which potentially could cost the NHS millions."*

The future

Would you like to see a pharmacist continue to be involved in the practice?
Respondents were unanimous in wishing to have a pharmacist continue to be involved in their practices.

How do you see the role of the HA's pharmaceutical adviser in the continuation of the scheme?

Respondents saw the value in having a pharmaceutical adviser being responsible for overall policy within the HA, providing guidelines and monitoring the scheme. Generally, they felt that the adviser had a strategic role and that the day-to-day advice and support came from their practice pharmacist.

If the HA withdrew funding for the scheme, would your practice explore other means of funding a pharmacist to continue this service?

Despite the overwhelming enthusiasm for having a pharmacist, only one respondent thought it likely that the practice would explore means for funding one. Others responses included that financial partnership with the HA was an option, that financing the role was the sole responsibility of the HA, and that PCGs might have a budget to fund such a post. However, the majority did not consider it likely that the practice would finance a pharmacist or even explore means to do so.

Can this type of initiative be accommodated with the advent of PCGs?
In addition to the continuation of pharmacists working in individual practices,

respondents were generally keen to see pharmacists involved at board level within PCGs.

GP2 "It would be nice to see it within a group. It would be nice to have an external force producing some sort of agreement within a group."

GP7 "I would have thought that any PCG that didn't have some pharmaceutical input is going to be in trouble."

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At the time of the practice pharmacist scheme, few studies had been conducted to evaluate the effectiveness of this type of collaboration.

The opinions of the GPs were constrained by limited prior experience of working with pharmacists. However, it was the aim of this study to obtain the unrehearsed opinion of non-pharmacist practitioners within the scheme before a further study to elicit the views of the collaborative pharmacists was undertaken.

The numbers involved in the study were limited but, while GPs expressed conflicting views on some matters, there was a high degree of consistency of opinion on many issues. Good working relationships were established, irrespective of whether the GPs had prior knowledge of the pharmacist or whether the pharmacist was local to the practice.

In all cases, the HA's objectives were acceptable to the practices. The objectives completed at the time of the interviews were achievable in all but two practices. Some had selected objectives without prior discussion with the pharmacist but subsequently acknowledged that more guidance from the HA and from experienced practice pharmacists could help determine their objectives in the future.

The work that pharmacists were able to do was constrained by their availability and by the accessibility of resources, such as rooms and computer terminals, within the practice. However, they were able to work independently within the framework of the

objectives and to provide feedback to the partners. To a large extent, it was the quality of the feedback on which the GPs judged them.

Feedback was both written and verbal in all practices but its content and regularity was inconsistent. In some multi-partner practices, the degree of involvement with the individual partners was variable. There may be value in pharmacists sharing their best practices for the provision of feedback to the practices.

Partners generally accepted recommendations from the pharmacists, although sometimes the GPs found it difficult to adopt all the changes proposed. There was often a lag between the recommendation and its implementation.

It was considered that appropriate audit should take place to determine the short- and long-term effects of the recommendations made. The general perception by the GPs was that drug costs within practices had decreased, although a quantitative evaluation would be required to verify this perception.

There was unanimous support for continuation of the scheme. With the advent of PCGs, pharmaceutical advice by pharmacists was perceived to be essential both at practice and PCG board level, a view which is in line with government policy.⁷ However, practices were unwilling to fund a pharmacist. GPs considered that any pharmacist with confidence, good communication skills and an interest in the work could become a practice pharmacist.

Few studies on the outcomes of GP/pharmacist collaboration have been reported. Reports on quantitative outcomes have been positive.⁸⁻¹¹ The results of this study, although based on a small number of subjects within a discrete geographical area, indicate that such collaboration would be welcomed by GPs and would be likely to lead to benefits for patients and prescribers in terms of rational and cost-effective prescribing.

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