

Pharmacists must learn to play their part in multidisciplinary health teams

In this eighth article in a series leading to a consultation about the Royal Pharmaceutical Society's Pharmacy 2020 project, **Alison Blenkinsopp**, professor of the practice of pharmacy at Keele University, and **Christine Bond**, professor of general practice and primary care at the University of Aberdeen, discuss the potential for pharmacy teams to improve the efficiency, effectiveness and quality of care delivered to patients

The potential for pharmacy teams to improve the efficiency, effectiveness and quality of care delivered to patients applies in both secondary and primary care. Our focus is both on teams within pharmacy and also wider teams to which pharmacy should be contributing. We provide examples of different sorts of pharmacy teams largely drawn from primary care, explore why they are particularly relevant in today's environment, and consider some generic principles of good team working. We conclude that pharmacy teams have never been more important and that the future will require more, not less, teamwork.

The range of intra-pharmacy teams and inter-professional teams which benefit from



pharmacy input are illustrated in Panel 1. At the simplest level, a pharmacy team would include all pharmacy-related staff, co-located and within the same organisational unit. An example of one of these teams could be a community pharmacy team or a hospital pharmacy team. In community pharmacy, the recently introduced pharmacy contracts and other NHS changes have created new roles

(eg, the medicines use review service in England and Wales) and developed others (eg, the national minor ailments service in Scotland and formalised support for self care activities in England and Wales). Transfer of work previously done by the pharmacist — by delegation to other staff within the pharmacy — has been the inevitable result of the need to increase capacity, as well as optimising the appropriate use of pharmacists' skills and knowledge.

Additionally, as in the wider NHS, community pharmacy has had to make its clinical governance processes more structured and visible and the new contract includes explicit clinical governance requirements; these also have resource implications. Together these changes have increased the need for the staff members within a community pharmacy to work as a professional team with roles and responsibilities of non-pharmacist staff made explicit and extended alongside those of the pharmacist (Panel 2). In such a community pharmacy team, members work alongside each other on a daily basis in the same location, and share a common purpose and vision; this model is what many would regard as a traditional team.

In contrast the concept of a pharmacy team which operates across different sectors of pharmacy is perhaps more difficult to envisage. These teams involve working across service boundaries and use mechanisms other than face-to-face communication. Here, members of community teams, the primary care organisation, general practice and hospital pharmacy teams network with each other to meet the needs of patients. The transfer of more care from hospitals to the community, increased efforts to prevent unnecessary hospital admissions, service redesign and the adoption of patient pathways for care are driving forces making both inter-pharmacy teams and pharmacist involvement in wider teams assume greater importance. Panel 3 shows an example involving community, practice and PCT pharmacy staff.

The "primary care team" has been, in the past, somewhat narrowly defined as those working within, or formally attached to, a general medical practice. Pharmacists were not normally considered part of the primary health care team, even when quite extended teams were described. The development of extended roles for health care professionals has led to a wider and more flexible primary care

Panel 1: Which teams could pharmacy be involved in and why

Team	Reasons why team working essential
Community pharmacy team	<ul style="list-style-type: none"> ■ New roles ■ Requirements of the new pharmacy contract and resource implications ■ Delegation of work from the pharmacist ■ Professional recognition for technicians ■ Professionalisation of medicines counter assistants, with mandatory training requirements ■ Increasing contribution of OTC medicines to self care, with the medicines counter assistant often as the first point of contact
Area pharmacy teams	<ul style="list-style-type: none"> ■ Need for closer collaboration across pharmacy settings to provide "seamless" patient experience ■ Communication about patients' medicines at admission and discharge ■ Ongoing communication post discharge re specialist medicines and devices ■ Hospital at home services and need for specialist pharmacy support
General practice teams	<ul style="list-style-type: none"> ■ Established role of practice pharmacists ■ Advisers on formulary/prescribing ■ Contribution to budgetary planning ■ Individual patient input ■ Supplementary and independent prescribing in specialist clinics ■ Promoting colleagues in community and hospital pharmacy
Area multidisciplinary teams	<ul style="list-style-type: none"> ■ Community pharmacist as core member of PHCT ■ Role in OTC medicine supply ■ Use of guidelines for OTC supply to be consistent with local formularies ■ Repeat dispensing ■ Medicines use review ■ Pharmacy contribution to public health ■ Working with social services ■ Formal referral to pharmacists and by pharmacist

Panel 2: Implementing the pharmacy contract — clinical governance requirements

The clinical governance requirements of the new pharmacy contract posed a considerable challenge to community pharmacists and their staff. For example, in England and Wales it is now mandatory for pharmacists to have systems to enable patient feedback, have monitoring visits from their primary care organisation or local health board, have risk management procedures in place (eg, maintain a log of patient safety incidents, have standard operating procedures), manage staff appropriately (eg, have induction and training programmes), participate in CPD and use information appropriately (eg, have confidentiality statements, comply with statutes such as the Data Protection Act, maintain PMRs). These changes have needed the involvement of all pharmacy staff and pharmacists have appointed a member of staff as the clinical governance lead for the pharmacy.

Panel 3: Primary care organisation-wide medicines management for older people

A primary care trust pharmacist, supported by a pharmacy technician, eight practice-based pharmacists and several community pharmacists provide a medicines support service for patients registered with 23 general practices. A primary focus for the service is the discharge of elderly patients from the local community hospital. The pharmacy technician carries out a medicines risk assessment before a patient is sent home. The community pharmacists take responsibility for overseeing the medicine management plan of individual patients in return for an annual fee for work ranging from taking on responsibility for patient medication within a locked box at home to up to detailed monitoring of a patient's medicines for a year.

(Adapted from Andalo D, When all pharmacists work together. Prescribing and Medicines Management, December 2004)



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Panel 4: Out-of-hours advice from a multidisciplinary team in primary care

Telephone advice from a multidisciplinary team comprising doctors, nurses and community pharmacists is provided from Fylde Coast Medical Services, an urban out of hours centre in Blackpool. Around 20 community pharmacists participate in the service and provide telephone advice to patients.

An audit of patient consultations showed that 45 per cent were for minor ailments, the commonest of these being: cough (32 per cent), temperature (19 per cent), sore throat (19 per cent) and ear ache (12 per cent). Analysis of the prescriptions written for minor ailments at Fylde Coast Medical Services before the introduction of the multidisciplinary service showed that 46 per cent were for non-prescription medicines.

Work has identified which patients can be streamed to the pharmacist or nurse rather than the GP.

Panel 5: Practice pharmacists and medicines management technicians

Based on their initial work interpreting and auditing prescribing data and advising GPs on their prescribing, practice pharmacists built relationships of trust and credibility with GPs, nurses and other practice staff. Having established a pharmacist role within the team they went on to conduct treatment review for specific groups of patients and then wider medication review clinics. Capacity to do this new work was partly created by transfer of basic prescribing analysis, prescribing audit and case finding work to medicines management technicians, with whom they worked closely. Leading-edge practice pharmacists then became some of the first pharmacist prescribers, their relationship of trust with practice GPs enabling them readily to find a designated medical practitioner for their qualifying training and to create referral routes from GP and nurse to pharmacist and vice versa.

team. Community pharmacists, most of whom do not have a formal association with general practices, and who often work in relative isolation from their professional colleagues, are challenged by the concept of how to be seen as a member of the team. However, as the range of activities and services delivered from community pharmacies widens the potential overlap with the work of the general practice is increasing, and there is a need for formal links to be made to ensure coherence of treatment approaches and full integration of pharmacy-delivered services with those other services based in the general practice. Provision, for example, of diagnostic testing on a private sector or NHS basis from pharmacies requires common referral thresholds, and over-the-counter recommendations should ideally comply with local treatment algorithms. The Government's targets for access to health care, and provision of services outside normal working hours provide further opportunities for multidisciplinary working (Panel 4).

Practice pharmacists (some of whom are also community pharmacists) work in the general practice setting as part of the practice team. The development of their team role is shown in Panel 5. Leading-edge practice pharmacists have recognised that they are in a position to build and strengthen local primary care team working with community pharmacists.

Working more effectively

Effective teams demonstrate high level collaboration, which in turn is dependent on high levels of trust, shared goals and clarity of roles. Research indicates that participation by community pharmacists (in primary care teams) continues to be low. Relationships of trust take time to develop, moving from co-operation to collaboration and require mutual recognition of skills and valuing of different contributions to patient care. Understanding each other's roles and responsibilities, with clarity on who will do what, is critical for ef-

fective teams. But primary care studies have shown that this is not always the case, even within different sectors of the same profession. Indeed "role specification" was found in one study to be the most influential factor supporting collaboration between pharmacists and physicians. In a major study of primary care teams, it was found that "the clearer the team's objectives, the higher the level of participation in the team". When considered in the light of these concepts of shared goals, role clarity and clear objectives, it becomes easy to understand, for example, why the new services such as medicines use review are not immediately seen as a primary care team activity.

For pharmacists to be accepted as members of wider teams they need not only to demonstrate an identifiable professional contribution but also to show that they work to the same principles and standards as other team members. Community pharmacists remain the only primary care clinicians who do

not routinely record all their clinical actions. Although it is understandable how this has arisen, and the additional workload is recognised, this is not a reason not to change now. Formal records, such as are suggested by the new contract, allow pharmacists to demonstrate the interventions they have made with patients and the valuable advice and treatment recommendations they have made regarding prescribed medicines, over-the-counter sales and other lifestyle issues. Such a record, ideally computerised, has the potential to ultimately be linked to a single electronic record.

It would also allow a clear audit trail to be maintained, and pharmacists' activities to be scrutinised by a third party, such as the primary care organisation. GPs, on the other hand, are used to their computer record data being interrogated to see whether they meet certain targets in the Quality and Outcomes Framework within their contract.

What more could be done?

Being an effective team member does not usually happen by chance or as a matter of course. Training in negotiating and influencing, and how to be a team player are important. These transferable skills are not currently core to pharmacy education and consideration should be given to this. Similarly building mutual trust requires knowledge of each other's training and understanding of differ-

ent team members' ways of working. Joint education at undergraduate and postgraduate levels is one way that has been proposed to support inter-professional team working before professional stereotypes become too entrenched. Community pharmacists and their staff do not always understand the world of general practice and vice versa so that misunderstandings easily arise. Most general practices and pharmacies would probably be happy to have a clinician colleague spend a few hours there to learn more about how things work.

As professionals, pharmacists and, more recently, registered pharmacy technicians are governed by their own rigorous Royal Pharmaceutical Society code of ethics. This covers both specific activities and generic issues such as patient confidentiality. Yet disappointingly, unlike with the medical code of ethics, which is known within and outside health care, it is not generally recognised by either patients or other health care professionals that there are requirements for pharmacists to comply with such a code. Indeed concerns about confidentiality have been cited as reasons why pharmacists should not have greater access to a patient's medical record and outside pharmacy there seems to be a lack of understanding about who, for example, has access to patient records on a pharmacy's patient medication record system.

Finally pharmacists, as autonomous profes-

sionals, have to be accountable and responsible for their actions and those of their staff. This is one of the seven principles of the code of ethics for pharmacists. Under the heading "Take responsibility for your working practices" the code sums it up succinctly: "Team working is a key feature of everyday professional practice and requires respect, co-operation and communication with colleagues from your own and other professions. When working as a part of a team you remain accountable for your own decisions, behaviour and any work done under your supervision."

Conclusion

With today's changing health care environment, with professional boundaries increasingly challenged and professions such as pharmacy taking on new roles, it has never been more important for health care teams to function effectively, in the interests of patient care. The contribution of pharmacy to health care is now acknowledged in Government policy, and pharmacists are seen as key front line health care professionals. Community pharmacists have traditionally been seen as isolated professionals and this is no longer a tenable position. All pharmacists must learn both to support teams within their own pharmacy and to play their full part in wider multidisciplinary teams operating across different levels of care.