

A day in the life of a

primary care pharmaceutical adviser

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As is often true in pharmacy, my career developed thanks to being in the right place at the right time, when I heard about an interesting project opportunity and decided to take the risk of going in a new direction. I really enjoyed working in a GP practice, but primary care work gradually took over more and more of my job "portfolio", until I found myself working full time in primary care and not looking back. My current role is largely strategic and managerial, but is varied and professionally fulfilling. I have found it a huge advantage to have had both hospital and community pharmacy experience before working in primary care, so that I can bring community pharmacy, public health and contractor perspectives and clinical expertise to every piece of work and every discussion.

Always busy

Pharmaceutical advisers are able to give input from a wide clinical and health service management perspective, and are seen as change agents able to find solutions to problems. This means

that we are valued beyond our pharmaceutical expertise and are always busy. As can be gathered from the National Prescribing Centre document "PCT responsibilities around prescribing and medicines management" and the accompanying competency framework for primary care pharmacists (www.npc.co.uk/npc_pubs.htm), interpersonal and communication skills are just as important to a pharmaceutical adviser as clinical expertise.

The day begins . . .

As always, the day starts with checking e-mail and post and what is booked in the diary for the day ahead. Just when it seems safe to start working on the complex shared care guideline that I have been developing with a consultant in my local hospital, the telephone rings with a query from a GP. The GP has been asked to start prescribing a new anti-epilepsy drug that he is not familiar with, and for which there is no local shared-care guideline. The GP asks for more clinical information about the new drug, what monitoring is required

and other patient care aspects and asks for my advice as to whether he should accept prescribing responsibility under these circumstances. Moreover, the patient has run out of the tablets dispensed by the hospital and is sitting in the GP's waiting room — he needs an answer straight away. After giving some preliminary advice to the GP to enable him to issue a prescription to meet the patient's immediate need, I use the next hour to research the full clinical information, another hour to contact the local consultant and GP, and then 20 minutes to log the query into our clinical database for future reference.

GP practice meeting

It is now time to drive to a GP practice where a lunchtime meeting has been arranged with all the GP partners and practice manager to discuss the prescribing analysis that I wrote and sent them a week ago. During a lively discussion, the GPs ask lots of questions related to clinical evidence behind some of my suggestions for improvement, and ask me to suggest how they could improve the prescribing

of antibiotics and ulcer healing drugs at their practice. The GPs also request the help of the PCT Pharmaceutical Team in reviewing their repeat prescribing system, and in helping with a review of their generic prescribing. After agreeing three practice action points with the GPs, I drive back to the PCT offices to write up a report of the meetings, and confirm the main points in a letter to the senior partner.

Medicines management

The PCT head of commissioning pops by to ask if I could contribute a section on medicines management, pharmacy and prescribing for the service level agreement (SLA) with the local hospital. A quick discussion establishes that my colleague would be happy for me to write a holding paragraph to insert into the SLA while a full document is developed and agreed with the local hospital team before the end of the financial year, so I start to map out what the section might contain, who would need to be involved in its development and how best to consult with all the stakeholders.

Falls prevention

By now, it is time to gather my thoughts and papers for a meeting on falls in older people, where I describe the clinical evidence for various prevention and treatment strategies, discuss and promote the role of community pharmacy in falls prevention, and discuss joint projects with social services and the local hospital discharge co-ordinator.

And finally . . .

At the end of my day, I have just enough time to touch base with my colleagues (who have had a similarly full day), reflect on what new knowledge I have gained and can contribute to my CPD portfolio. I realise I have discovered new learning needs around commissioning and feel guilty for not having found time to record it all.

I can also reflect on how much I have enjoyed the professional challenge of my busy job today, and how glad I am to be going home. ☺